GMMMG
Greater Manchester
Medicines Management Group
NHS

Greater Manchester Medicines Management Group

Minutes of the meeting held on
Thursday 14th July 2022, 1- 3pm

Virtual meeting

Present:

Name	**Title**	**Organisation**	**Representing**	**Aug**	**Oct**	**Nov**	**Feb**	**Mar**	**May**	**Jul**
Dr Helen Burgess (HB)	GP MO Prescribing lead	NHS Manchester CCGs	GPs	✓	A	✓	✓	✓	A	✓
Petra Brown (PeB)	Chief Pharmacist	Pennine care NHS FT	GM Mental Health Organisations	✓	✓	✓	✓	✓	✓	A
Kate Rigden (KR)	Chief Finance Officer	NHS Oldham CCG	CCG finance leads	AF	✓	✓	✓	✓	✓	✓
Mina Patel (MP)	Trust Finance Officer	MFT	Provider Finance						✓	✓
Jay Hamilton (TBC)		HiM	Health Innovation Manchester (HIM)				TV	A	✓	A
Dr Ann Harrison (AH)	GP MO Prescribing lead	Trafford CCG	GPs	✓	✓	✓	✓	A	✓	✓
Robert Hallworth (RH)	Specialist Cancer Pharmacist	NHSE	NHSE Specialised Commissioning	✓	✓	✓	✓	✓	✓	✓
Dr Pete Budden	GP Prescribing lead	Salford CCG	GMMMG Clinical Reference Subgroup							✓
Peter Howarth (PH)	Head of Medicines Management	Tameside & Glossop CCG	CCG MO leads	✓	✓	✓	✓	✓	✓	✓
Aneet Kapoor	Chair of the GM LPN	LPN	Pharmacy profession	✓	✓	✓	✓	✓	✓	✓

Vacant seat			GM Secondary Care Clincians							
Peter Marks (PM)	LPC Board Member	GM LPC	Community Pharmacy	✓	✓	✓	A	✓	✓	✓
Chris Haigh (CH)	HOMM	Bolton CCG	CCG MO leads and GMMMG Digital subgroup							✓
Luvjit Kandula (LK)	Chair – Community Pharmacy Provider Board (CPPB)	GM LPC	Community Pharmacy	✓		A	A	✓	✓	A
Lara Shah	Deputy HOMM	MHCC	GMMMG Population health and inequalities subgroup							✓
Fiona Meadowcroft (FC)	Interim Deputy Director Strategy – Integrated Care	MHCC	CCG Commissioning lead	✓	✓	✓	✓	JW	A	A
Kenny Li	HOMM	MHCC	GMMMG Medicines Value subgroup						✓	A
Faisal Bokhari	Deputy HOMM	T&G CCG	GMMMG Pharmacy workforce subgroup						✓	✓
Karen O'Brien (KO'B)	Regional Pharmacist	NHSEI	NHSEI	✓	✓	✓	✓	✓	✓	A
Rob Bellingham	Managing Director Greater Manchester Joint Commissioning Team	The GM Joint Commissioning Board (MO)	Joint Commissioning Board		✓	✓	✓	A	✓	A
Paul Buckley (PaB)	Chief Pharmacist	Stockport FT	GM Chief pharmacists	✓	A	✓	A	A	✓	✓
Steve Simpson (SS)	Chief Pharmacist	Bolton FT	GM Chief pharmacists	A	✓	✓	✓	✓	✓	A
Charlotte Skitterall (CS)	Chief Pharmacist	Manchester FT	Chair	✓	✓	✓	✓	✓	✓	✓

Claire Vaughan (CV)	Head of MO	Salford CCG	Vice Chair of GMMMG and GMMMG Medicines Safety subgroup	A	✓	✓	✓	✓	✓	✓
Dr Sanjay Wahie (SW)	Clinical Director	NHS Wigan CCG	GPs	A	✓	✓	✓	✓	✓	A
Dr Peter Elton	SCN representatives	Strategic Clinical Network	Strateic Clinical Network	✓	A	✓	✓	✓	✓	✓
Vacant seat			Provider Board representative							
Vacant seat			Council representative for GM Social Services							
Vacant seat			GM Medical Directors							
Vacant seat			Lay representative							
Vacant seat			GM Public Health							
Sue Dickinson (SD)	Director of Pharmacy	RDTC	SPS	A	✓	A	A	A	A	A
Monica Mason (MM)	Head of Prescribing Support	RDTC	Professional secretary	✓	✓	✓	✓	✓	✓	A
Andrew Martin (AM)	MO Pharmacist	GM Joint Commissioning team	GMMMG support	✓	✓	✓	✓	✓	✓	A
Andrew White (AW)	Head of MO	GM Joint Commissioning team	GMMMG support	✓	✓	✓	✓	✓	✓	✓
Dan Newsome (DN)	Principal pharmacist	RDTC	GMMMG support		✓	✓	✓	✓	✓	✓

1. General Business

1.1 Apologies

As above.

1.2 Declarations of Interest

Nil declared.

2.0 Minutes and actions from the last meeting

Minutes from the May meeting had already been approved virtually and there was no June meeting.

AW informed the group that the workplan is yet to be completed and will be submitted for the next meeting. Questions were raised about the GMMMG Charter (agenda item 4) and how it relates to the workplan which led to a full discussion of this agenda item at this point of the meeting.

The group heard that in the absence of a workplan, the GMMMG Charter was developed to define the strategic direction of GMMMG. The Charter does not negate the need for a workplan as the workplan would detail the workstreams and programmes that will need to be delivered in line with the Charter.

It was pointed out that the specific activities listed in the Charter do not necessarily align with the current IPMO workstreams and that IPMO groups should review their workplans and agendas to align with the Charter.

An update to the Charter to explicitly include the improvement of the health and wellbeing of the GM population, preventing ill health, and the provision of medicines assurance was suggested and agreed.

The group agreed to accept the Charter (with above update) recognising that its development would be an iterative process.

With regards to the IBD pathway, AW noted that progress is on hold due to awaiting the publication of updated guidelines from the BSR on pregnancy and breastfeeding, expected in September 2022, as this will have an impact on the content of the pathways.

Action: Workplan to be submitted for next GMMMG meeting, Charter to be updated as above.

3.0 Subgroup decisions for ratification

Prior to discussing the subgroup recommendations, the issue regarding where the authority to approve these decisions lies under the new ICB structure was raised, which also led to a full decision of agenda item 5 at this point.

It was noted that under the previous CCG structure, GMMMG understood that they as a committee had delegated authority where there were financial implications of ≤£200k. Above this threshold, approval was required from DoCs/ CFOs. KR explained that previously, authority for approval ≤£200k was in fact with DoCs and >£200k was with CFOs. CFOs will carry on into the new structure but will have no delegated authority.

The only parties with authority at present are the GM ICB executive team or where delegated to Place leaders, though this is yet to happen. KR suggested that in the interim, the recommendations should be forwarded to Sam Simpson (CFO) and Warren Heppolette (Strategic Planning Lead) with a question seeking clarity on the most appropriate place to get the decisions ratified in the absence of committees below the board.

The paper (agenda item 5) requesting delegated authority was raised and it was asked if the proposal for GMMMG to have delegated authority up to £1m should be submitted at the same time as sending the recommendations. KR believed that it would be challenging for GMMMG to have delegated authority since the group is not a budget holder. Budget holders are currently either hospitals or locality Place leads and GMMMG may only make recommendations to be ratified by these parties. GMMMG could ask for delegated authorities for decisions with no financial implications, but where there is, the current thinking is that decision making would need to remain with budget holders.

Group members expressed concern that having no delegated authority would be very difficult for GMMMG in terms of making decisions and giving delegated authority to subgroups. It would be an inflexible system resulting in a delay to decisions making, and could threaten the existence of a single ICS decision-making group for medicines. Further concern was expressed that without a single decision-making group for the ICS and if it only has authority to make recommendations, this increases the risk that each place may make different decisions and could decline to adopt GMMMG recommendations, further increasing disparity in service provision and access and subsequently inequality in GM.

Clarity was also requested on where the clinical governance approval sits as wells as financial.

It was agreed that the conversation needs to be continued outside the meeting and the proposal for delegated authority would need to be amended following this discussion. A group will be convened to discuss further

and make amendments to the proposal before submitting. Any members who wish to be involved in the discussions should let DN know.

The discussion moved on to the subgroup recommendations. It was noted that there are potential savings of up to £180k arising from assigning a DNP status to simple eye ointment. There was some discussion on how this saving would be transacted/delivered and how it can be ensured that the saving opportunity is not lost. It was noted that mechanisms in place for GMMMG to realize the outcomes/benefits from decisions are the formulary, RAG list and DNP lists with the expectation that locality leads ensure that their teams are adhering to these. The importance of assurance was also raised, and the group agreed that regular monitoring is important to ensure that decisions made by GMMMG are being enacted at a local level. There was some suggestion that the Value group could be asked to look at the savings opportunity with the simple eye ointment but it was explained that the Value group's objectives are seen by ICS Finance Directors as longer term, strategic, projects to achieve large scale savings rather than in year operational work and monitoring, which are expected to be delivered by locality medicines optimisation teams. It was suggested that the JCT team would be well placed to support monitoring and reporting on in year savings delivery as they have done for other items in the past. AW agreed to the JCT team looking at a proposed dashboard for providing assurance on the implementation of decisions made by GMMMG on a regular basis.

It was noted that TA775: Dapagliflozin for treating chronic kidney disease has an estimated impact of £136k in year 1, rising to £668k in year 5 according to the NICE resource impact template. As a NICE TA, prescribing will happen anyway, but the cost impact should be noted and will need to be flagged to the relevant leads. The other decisions do not have significant financial/ commissioning impact but there were a couple with some impact e.g. £40k but it was agreed that all decisions should be sent to afore mentioned contacts particularly in this initial phase while the governance process is clarified.

Regarding utrogestan for preventing miscarriage, it was queried whether there had been a link in with maternity networks and the SCN and if there had been discussions with Cheshire and Mersey as maternity is a service that crosses boundaries. DN clarified that there had been discussions through CRG pharmacists with Trust maternity services to reach an appropriate status applicable across GM. CRG also usually checks formulary status in other areas but these are not always available especially where new medicines/indications are yet to be considered. The decision will be communicated to all localities, and it is expected that locality leads will assess the potential impact of decisions locally and have any necessary onward conversations.

A general point was raised regarding how GMMMG works together with the SCN in making decisions. It was suggested that a representative of GMMMG should meet with the SCN to discuss how best to work together. AW agreed to liaise with PE about this with a view to bring a proposal back to GMMMG for consideration.

GMMMG were in support of the recommendations made by CRG and agreed for them to be forwarded to the parties mentioned earlier.

Actions: DN to forward recommendations to Sam Simpson and Warren Heppolette as above; group to be formed to discuss decision making/ delegated authority, interested members to let DN know; JCT to propose dashboard for providing assurance to GMMMG on a regular basis; AW to liaise with PE regarding collaborative working with SCN and bring proposal back to a future meeting.

4.0 GMMMG Charter

See item 2.0 above

5.0 Greater Manchester ICS Decision-Making for Medicines

See item 3.0 above

6.0 GM HCD Update

Following on from previous conversations, the risks raised by GMMMG regarding HCDs were escalated up to the Elective Care Reform Board (ECRB). The ECRB have approved an interim HCD panel who will have decision making ability. The standard operating procedure (SOP) and Terms of Reference (ToR) for this panel were provided for information. These documents are for approval by the ECRB but were provided to GMMMG to have an opportunity to raise any potential concerns prior to submitting to the ECRB. It is anticipated that the new panel will start operating in the next few weeks. The panel will primarily be considering cohorts aiming

to ensure equity of access. The impact of the new arrangement on GMMMG will mainly be on CRG who will be asked to approve clinical policies being developed from evidence reviews.

It was emphasised that there should be assurance back to GMMMG ideally 3 monthly initially to gain understanding of how this new arrangement is working. AW noted that the ECRB have asked for 3 and 6 monthly reports and these will be fed back to both the ECRB and GMMMG.

It was noted that the ToR includes service developments but the membership of the panel does not reflect suitability for looking at service developments. AW explained the idea is that clinical policy development will be done using GMMMG as a network to link with those involved with service development.

Clarity was requested regarding how it links to block arrangements, and that there should be some consideration on how it feeds into the planning for HCD for the next financial year. There were also questions around homecare capacity and costs which is not included in the block contract. Issues may arise if there is an assumption that Trusts will automatically take on delivery/homecare costs associated with decisions made by the panel. This might result in different levels of uptake across Trusts which would lead to inequalities and different levels of access.

The comments and concerns were acknowledged and GMMMG will review the situation with the assurance report due in September and escalate as necessary.

Action: AW to submit September assurance report for appropriate GMMMG meeting.

GMMMG subgroup reporting

7.0 GMMMG subgroup Terms of Reference (ToR)

ToR have been developed for all of the GMMMG IPMO workstream subgroups. The ToR were developed based on the template used for CRG and in collaboration with the Chairs of the groups.

Some discrepancies were noted between the ToRs of the various groups for example differences in quorum arrangements and differences in the number of priorities presented by groups. It was also noted that there is inconsistency in style and terminology used, and that care should be taken with some terminology e.g. "primary care"; it should be made clear what this means i.e. does it cover the gamut of primary care services or is it only referring to general practice. It was agreed that some work is needed to align the ToRs and ensure consistency across all as much as possible. They should also be checked to ensure alignment against the GMMMG Charter and include a small number of agreed priorities (up to five).

The issue of delegated authority to the subgroups was raised to be considered within the ToR. However, given earlier discussions, it is difficult to address this until previous points are addressed.

It was agreed that the minutes of the subgroup meetings should be published on the GMMMG website. However this would mean that they should be suitably prepared with the appropriate level of detail and in a consistent manner. It was also requested that care should be taken with papers in general to ensure that they are appropriately detailed as they are subject to Freedom of Information Requests.

All subgroups have reported limited capacity to deliver the work streams. This highlights the importance of setting priorities to focus on as well as putting appropriate timescales to complete workstreams.

Action: Subgroup chairs to review ToRs as above supported by AW and return to next meeting.

8.0 Medicines Safety

- Valproate: The group now have more assurance on primary care activity and are working further to gain pathway assurance across secondary care. A shift will be required in how patients are managed; the current system for annual reviews is a "push" system but needs to move to a "pull" system.
- Sector specific work is slightly behind; locality MO leads are focussing on drugs for dependence in line with QOF and have produced a Charter which will be going to the next meeting. The group needs to consider how to progress other sector specific work.
- Have formed links with Health Innovation Manchester (HIM) who now attend the group and are working together to avoid duplication in areas of improvement being requested of frontline teams.

- The group sought confirmation on the update of the GMMMG Opioid Resource Pack and the approximate timescales for its completion. The JCT team are currently working on the update and will update the medicines safety group on the progress.

9.0 Pharmacy Workforce

- The group have worked on their ToR and refined priorities and work plan.
- A situational analysis of the current pharmacy workforce had commenced with career mapping and opportunities completed.
- The group previously intended to develop a pharmacy dashboard, but another team in GM is working on something similar (VWIS project), so they are instead providing support for the development of this dashboard from a pharmacy perspective.
- Also formed links with HIM on key priorities like polypharmacy to define roles and responsibilities for community pharmacy and pharmacy technicians supporting polypharmacy reviews.
- Developed links with University of Manchester to discuss increasing undergraduate placements in all sectors. A University representative will be start to attend meetings. Concerns were raised regarding capacity for supervision of undergraduates on placements in primary care settings and the risk of increased pressure on already stretched GP services if numbers are increased. FB stated that this will be taken into consideration when discussing the placements, and that requirements for clinical supervision is an area that will be looked into as the supervisor doesn't have to be a GP, though acknowledging that other primary care staff apart from GPs are also stretched. PM suggested that it might be useful for FB to attend the regular meetings held by the University to discuss placements.
- Update on regional 8c and band 7 integrated pharmacy posts: the 8c post will be recruited into once the GMIC chief pharmacist is in post but there are ongoing discussions on whether the post will sit under primary care commissioning or clinical professional leadership. It is currently not clear where the Band 7 post will sit.
- Clarity was sought on whether a workforce strategy is being developed for GM. FB explained the aim is that the output of current workstreams including the situational analysis and VWIS dashboard development will support the development of a GM 5 year strategic plan for the pharmacy workforce and the group hope to have a draft strategic plan by March 2023.
- It was suggested that the group may want to consider collaborating with Liz Fidler (president of the Association of Pharmacy Technicians UK), who is working on the development of technical services and highlighting the skills of pharmacy technicians.

10.0 Clinical Reference Group

- The minutes from the May and June CRG meeting were noted.
- The DOAC statement developed in response to the NHSE procurement exercise is currently out for consultation. The issue of switching was a main discussion point for CRG, particularly considering that current edoxaban prescribing levels are nowhere near levels that would achieve the savings benefit target. However, CRG found it difficult to get a consensus that switching should be advocated. One area of concern was around whether it is appropriate to switch patients to edoxaban and then back to apixaban in several months' time with potential availability of apixaban generics. CRG decided neither to advocate for, nor advise against switching in the statement.
- The SCN have been asked to lead on discussions about equitable access to continuous/flash glucose monitoring. Concern was raised at the last CRG meeting regarding speed of access for patients especially given the heavy national attention on the topic. It would be helpful for GMMMG to have assurance that progress is being made to address this. PE mentioned that clinicians in the SCN had discussed it but sought clarity on GMMMGs expectations of the SCN for this piece of work; DN will liaise with PE accordingly, and this could also be picked up alongside discussions on how the SCN and GMMMG work together. It was also highlighted that workforce implications should be considered for diabetes technology and not just prescribing costs.
- CRG agreed at their last meeting to put out the recently published National Shared Care Protocols for GM wide consultation as a batch. The group are not seeking comments on the content, rather

comments are being sought on the applicability of the SCPs in GM. Any content issues will be flagged to the NHS England Medicines Policy Team for action as appropriate.

11.0 Health Inequalities (no paper)

- The group have been focussing on smoking cessation and vitamin D however, there has been limited capacity to progress the workstreams. There is a plan to meet with the leads of the workstreams to simplify what needs to be delivered e.g. for vitamin D, specifically addressing vitamin D in pregnancy rather than producing guidelines. It was mentioned that there are some differences in the views of SCN clinicians and others involved in the vitamin D work stream which needs to be worked through.
- The group are also considering the process for equality impact assessment for different areas e.g. CV disease
- With regards to smoking cessation, there was a suggestion that the group could try to link in with the CURE project which has started to be rolled out across GM.

12.0 Medicines Value (no paper)

- Clarity was requested on the format to be followed for the terms of reference for the general points.
- The group recently met with CFOs to give an update on the initial primary care savings plan.
- The group are also considering how assurance on workstreams will be managed and how best practice will be shared.
- Now at a point of allocating workstreams to individuals to start making progress.

13.0 Digital Enablers (no paper)

- The group are carrying out a review of BI resources looking at what data sources are available.
- Also working with the digital office on their pharmacy digital investment prioritisation exercise.
- A Position statement and PIL on online medicines ordering is in development. This will be submitted to the GMMMG in due course.
- GM care record work is ongoing.

It was requested that all subgroups submit written reports to support the agenda item and give group members a chance to review. It was also requested that any recommendations from subgroups comes through GMMMG before it goes further up the governance process for approval.

Action: AW to look at standardising information for ToR to support consistency across all.

Associated committees reporting

14.0 GM MO Localities

Noted

15.0 GM Net Zero Board

Noted. The request that sign-off of GM decision support and implementation tools to enhance uptake of greener inhalers is delegated to CRG (or chair for expedience) in conjunction with NHS GM clinical lead was approved.

16.0 GM Antimicrobial Steering Group

Noted. Priority topics are prescribing in under 5s and UTIs (linked to CQUIN). Some good work done in Trafford on reducing antibiotic prescribing in children. Using the AMS group as an avenue for sharing best practice. Acknowledged that the UTI CQUIN is a challenge as there is no penalty for non-delivery and there is more focus on the antimicrobial targets in NHS contract. Also, collection of data would be very difficult without an electronic system. CQUIN lead for GM is aware of this and acknowledges that progress may be more qualitative than quantitative this year.

Date of next virtual meeting: Thursday 11th August 2022, 1 – 3pm