Minutes of the GMMMG Clinical Reference Group Meeting
Tuesday August 9th 2022, 12:00-14:00
via MS Teams

Name	Title	Organisation	Mar	Apr	May	June	July	Aug
Dr Peter Budden (PB) Chair	GP	St Andrews Medical Practice		✓	✓	✓	✓	✓
Dr Helen Burgess (HB)	GP	Manchester Health and Care Commissioning		✓	A	✓	A	✓
Dr Jonathan Schofield(JS)	Consultant Physician Acute Medicine & Diabetes	Manchester FT	✓	✓	✓	A	A	A
Sarah Boulger (SBo)	Medicines Information Pharmacist	Pennine Acute	✓	A	A	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	A
Andrea Marrosu (AM)	High-cost Medicines and Home Care Pharmacist	Salford Royal FT	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	A (MC)	A (MC)	A
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	Bury CCG	✓	SM	✓	A	✓	A
Steven Buckley (SB)	Director of Pharmacy	GM Mental Health FT	A	A	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	✓
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	✓	✓	A (AH)	✓	✓	✓
Jole Hannan (JH)	CCG Interface Pharmacist	Bolton CCG	✓	✓	✓	✓	✓	A
Jacqueline Coleman (JC)	Medicines Optimisation, Interface Pharmacist	Stockport CCG	✓	A	A	A	A	A
Charlotte Atkinson	Specialist Pharmacist	Manchester FT				✓	A	✓
Consultant Rheumatologist Audrey Low Ben Parker		SRFT MFT	✓ AL	✓ AP	A	✓ DR	A	✓ SN

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

1. General Business	
1.1	**Welcome and apologies** The chair welcomed the group and noted apologies as above. Sophia Naz (Consultant Rheumatologist, Northern Care Alliance NHS Foundation Trust) and Susan McKernan (Acting Head of Medicines Optimisation, Bury) attended for the first time.
1.2	**Declarations of interest** Previously declared where relevant. No new declarations of interest were disclosed.
1.3	**Draft July 2022 CRG Minutes** The July 2022 CRG Minutes were accepted as a true record.
1.4	**Action log review** Most items had no updates, the action owners will be approached for updates. Some items have full agenda items. Others have progress as follows: • There has been progress on the **steroid eye drops review** (O2223.2) and an update is expected in September or October 2022. • **Dacepton** (Aporphine; O2223.3) not yet added as per February consultation as the updated shared care protocol (SCP) is still pending. Another factor is a pending RAG review from MFT, who propose GREEN (specialist initiation), which is awaiting local D&T approval. CA confirmed that it is on the MMC agenda for this week. Pending outcome of that discussion, an SCP and/or RAG review will come to September CRG. SRFT do not endorse the RAG change, feeling that extensive secondary care input is needed and would prefer it remain a shared care medicine. There was some discussion about ordering of Dacepton and APO-go on formulary and it was clarified that the two medicines will be equal first line options, as per the minutes of CRG in February 2022. Concern was raised that there may be conflicts of interest with these medicines. DOIs will be sought for the full discussion as per GMMMG process. • The draft leaflet for **modafinil** (O42204) is now ready for consideration at the September 2022 CRG meeting. • An updated draft guidance and pathway for **HRT** (122102) is expected at the September 2022 CRG meeting.

	• With regards to **access to Flash/isCGM** (072202), work is still ongoing and there has been some recent delays. SCN were planning to discuss and provide support, and AMart is undertaking work to ascertain expected patient numbers. It was highlighted that the NICE guidance asks for active measures to address inequalities in access to isCGM. • The **hypersalivation pathway** (052202) is still in development, consultation comments have been fed back to the authors.
1.5	**Update from GMMMG** Decisions from CRG currently have no agreed route of approval. GMMMG had delegated authority on behalf of all ten GM CCGs to make decisions but, following the move to an ICS, decisions are currently being submitted to the ICB Directors of Finance for approval. This is delaying updates to the formulary and web site. Work is ongoing with the newly appointed ICS medical and finance directors for delegated authority to be reinstated, and patience is requested in the meantime. There was a query as to whether anything can be done at locality level to expedite this since localities hold the primary care budgets. The group heard that this is all being considered centrally and at present there is nothing more to be done.
2.0 Matters arising	
2.1	**CRG Consultation June 2022** Comments were acknowledged, and it was agreed to send the contents to GMMMG for approval. One comment requested that macrogol 3350 be added to the DNP list. There was some discussion around positioning of romosozumab and it was agreed that this is a decision best made by specialists on a patient-by-patient basis, with no need for more prescriptive guidance. The NOGG guidance was agreed to be a good starting point. It was highlighted that there may be service implications, and a clinical pathway may be needed, but patient numbers are likely to be small. It was acknowledged that initiation would be in secondary care, but a simple pathway would be helpful to provide assurance to primary and secondary care and finance teams. **Action**: RDTC to submit actions to GMMMG for approval. The request for macrogol 3350 to be DNP will be brought back to a future meeting. SN to take the romosozumab action to the GM rheumatology high cost drugs group for discussion.
3.0 Formulary and RAG	
3.1	**Formulary Amendments July 2022** CRG approved the formulary amendments to open for consultation and noted the following: **1.** TA803: Risankizumab for treating active psoriatic arthritis after inadequate response to DMARDs This is being referred to the psoriatic arthritis pathway authors. **2.** TA805: Icosapent ethyl with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides The proposed RAG status of Green (Specialist Advice) was discussed. It was noted that a pathway is being drafted for lipid management, and this may help with therapy choice when available. The possibly significant cost impact, particularly if this was Green, was noted. It was agreed by the group that the RAG status would become clearer when the place in the treatment pathway is identified. CRG understood the AAC/NHSE to be updating the national lipid pathway to include this

	medicine, and would propose a Green specialist recommendation status for the consultation in line with a request from JS. It was noted that this item is on the agenda for the MFT Drug and Therapeutics group on Thursday (11th August). **3.** TA807: Roxadustat for treating symptomatic anaemia in chronic kidney disease This item was highlighted, and it was noted that this is the first in a series of oral treatments expected to be reviewed. These are the first oral treatment options (as opposed to injectable treatment) for this indication. **Action: RDTC to open formulary amendments for GMMMG consultation**
3.2	**Famotidine new medicine request** This is a request for famotidine 20mg and 40mg tablets to be added to the GMMMG formulary for the treatment and maintenance of duodenal ulceration and reflux oesophagitis. It was clarified that this is just for adult patients, will replace ranitidine, and is already being prescribed across GM. Whilst there is a possible ongoing supply problem (in that stock levels will not support wide-spread prescribing as there previously has been with ranitidine), it was suggested this gives primary care teams more options for management. **Decision**: **Approved to open for consultation.**
4.0 Pathways and Clinical Guidelines	
4.1	**DOAC statement** Comments have been received on this statement following a GM-wide consultation process. Primary care clinicians were generally in favour of a position to switch, whereas secondary care clinicians were generally against switching stable patients onto alternative DOACs and were concerned that the position may deprive clinicians of choice in DOAC prescribing. Amendments have been made in line with feedback and in line with the IIF and recent statements from NHSE on the best value DOAC. It has also been clarified in the statement that severe uncontrolled hypertension is a contraindication for all DOACs, and that if a DOAC other than edoxaban is chosen then a reason for this must be documented. It was asked whether the RDTC DOAC comparison document could be made open access to aid in sharing it with primary care teams, though it was explained that access is currently limited to RDTC stakeholders, including GMMMG, DN would check if this could be facilitated. CRG heard that hosting a document in more than one location may generate issues with version control and so ideally should be avoided. **Decision: DOAC statement approved to go to GMMMG for ratification.**
4.2	**Greener respiratory care** It was explained that this work is being developed to support the implementation of the IIF indicators for greener inhaler use, and the intention is that these will be GM-endorsed posters for use in practices and on social media. The development team has included a primary care group consisting of GPs, pharmacists, and nurses, and these posters have been trialled in a number of practices so far. This current draft is based on those developed through this process.

	Minor comments were passed onto AW regarding grammatical changes and layout. It was also suggested that the 'Inhaler Technique Service' is added on for information. CRG were granted permission by GMMMG in June to approve the documents without the need for a consultation to aid timely dissemination and use. **Decision:** Approved for publication
5.0 Shared care	
5.1	**Melatonin SCP** This updated draft of the melatonin shared care protocol (SCP) incorporates changes previously suggested, including more information about trial discontinuations, especially when moving from paediatric to adult services, and the addition of Adaflex® as the first-line option. A previous draft has been out for consultation. The potential for confusion where the SCP states the specialist will discontinue treatment if needed, and the GP trialling discontinuation in some cases, was noted. Broken links were highlighted, and it was noted that the guidance for Adaflex® and food needs changed to reflect licensing. It was also pointed out that the current draft refers to 'CCGs'. The choice of products was discussed. It was noted that the CAMHS team wanted off-label use retained for Slenyto which is considerably more expensive than Adaflex or Circadin. It was suggested that even with the higher cost Slenyto products on the SCP, if Adaflex® is being used as a first-line option then the expectation is that *overall* cost of melatonin use will decrease, however CRG asked for prescribing data to be available in 6 months to check actual usage is in line with expectations. CRG also had concerns that the new wording could be interpreted as normalising primary care management of prescribing into adulthood when a patient is discharged from paediatric services. It was discussed and agreed that patient and parent/carer expectations should be managed by specialist prior to discharge and the medicine stopped if possible. Some improvements on this issue have been seen in Manchester thanks to good relations between the MO team and CAMHS but this is not consistent across GM Despite some problems with the implementation, CRG recognised they could not solve all the issues and approved the documentation for use. **Decision: Approved to go to GMMMG for ratification, and noted that prescribing data for melatonin products will be monitored for assurance in 6 months time.**
6.0 Work plan and horizon scanning	
6.1	**Horizon scanning July 2022** CRG noted the contents of the document, and two items were discussed. **1. Semaglutide for weight management** Concern has been raised by some MO leads within the GM area about the cost of implementation and access to services if the TA is published in current draft form. (Current FAD for use adults is positive, and TA in development for ages 12-17.) Access to Tier 3 Weight Management Services is not consistent across GM, and if the TA is positive it will recommend wide access to GLP-1 agonists for weigh management. The cost impact could be up to around £30m for GM area if the liraglutide cost-template is followed and offered to 5% of eligible individuals. However access to tier 3 services, again, is likely to limit uptake. GMMMG will need to look at this carefully and view the intervention as NICE intended as an investment in public health, before deciding on affordability.

	2. **Lasmiditan (Rayvow®▼, Eli Lilly)** This is a first-in-class agent, and is a possible treatment option for those who cannot take triptans. Was also noted that remigepant is upcoming, too, and suggested that feedback will be sought (internally) from clinicians at Salford involved in migraine pathway.

7.0 AOB

1. NICE TA814: Abrocitinib, tralokinumab or upadacitinib for treating moderate to severe atopic dermatitis

TA814 was highlighted, and it was asked whether a pathway will be required. AW stated the recently approved RMOC recommendation that all NICE approved HCDs will routinely be commissioned may negate the need for a pathway.

2. **ICS structure and commissioning**

With the 30-day NICE TA deadline for abrocitinib (in NICE TA814), it was asked how this will be commissioned locally. AW clarified that it isn't clear how this will happen yet, and it is being discussed with ICB finance and Medical Director.

3. **Andrew White's departure to South Cumbria and Lancashire ICS Chief Pharmacist role**

AW thanked group for support, and group thanked AW for all his help and wished him the best for the future.

Date of next meeting: Tuesday 13th September 2022 12:00-14:00 via Teams