Minutes of the GMMMG Clinical Reference Group Meeting
Tuesday October 11th 2022, 12:00-14:00
via MS Teams

Name	Title	Organisation	May	June	July	Aug	Sept	Oct
Dr Peter Budden (PB) Chair	GP	St Andrews Medical Practice	✓	✓	✓	✓	✓	A
Dr Helen Burgess (HB)	GP	NHS GM IC (Manchester)	A	✓	A	✓	✓	✓
Dr Jonathan Schofield(JS)	Consultant Physician Acute Medicine & Diabetes	Manchester FT	✓	A	A	A	✓	✓
Suzanne Schneider (SS)	Medicines Information Pharmacist	Bolton FT	✓	✓	✓	✓	✓	✓
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	NHS GM IC (Heywood, Middleton & Rochdale)	A	A (MC)	A (MC)	A	A (MC)	A
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	✓	A	✓	A	✓	✓
Steven Buckley (SB)	Director of Pharmacy	GM Mental Health FT	A	A	A	A	✓	✓
Faduma Abukar (FA)	Head of Medicines Management	NHS GM IC (Stockport)	✓	✓	A	✓	A	✓
Zoe Trumper (ZT)	Assistant Director of Medicines Management	NHS GM IC (Wigan)	✓	✓	A	✓	A	✓
Faisal Bokhari (FB)	Deputy Head of Medicines Optimisation	NHS GM IC (Tameside)	A	✓	A	✓	A	A
Jennifer Bartlett (JB)	Team Leader Neighborhood Integrated Practice Pharmacists	Salford Royal FT	✓	✓	✓	A	A	✓
Claire Foster (CF)	Senior Medicines Optimisation Adviser	NHS GM IC (Manchester)	A (AH)	✓	✓	✓	✓	✓
Jole Hannan (JH)	CCG Interface Pharmacist	NHS GM IC (Bolton)	✓	✓	✓	A	✓	✓
Jacqueline Coleman (JC)	Medicines Optimisation, Interface Pharmacist	NHS GM IC (Stockport)	A	A	A	A	A	A
Charlotte Atkinson	Specialist Pharmacist	Manchester FT		✓	A	✓	✓	LL
Consultant Rheumatologist Audrey Low Ben Parker Charlie Filer Dipak Roy Louise Mercer		SRFT MFT Stockport TGH Stockport	A	✓ DR	A	✓ SN	A	✓ (SW)

Meghna Jani Sahena Haque Anindita Paul		SRFT UHSM Bolton						
Dan Newsome (DN)	Principal Pharmacist	RDTC	✓	✓	✓	✓	✓	✓
Nancy Kane (NK)	Senior Medical Information Scientist	RDTC	✓	✓	✓	✓	✓	✓
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	✓

1. General Business	
1.1	**Welcome and apologies** HB chaired the meeting in PB's absence. The chair welcomed the group and noted apologies as above.
1.2	**Declarations of interest** Previously declared where relevant. DN noted for item 3.6 (RDTC Formulary Application Proposal), the RDTC is contracted by what was GM Joint Commissioning Team to provide support to GMMMG.
1.3	**Draft September 2022 CRG Minutes** The September 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: • **052202 Hypersalivation pathway**—It was noted that further contact is awaited from authors, and suggested that the RAG amendments are approved as-is in November 2022 if pathway is not yet available rather than waiting for this. • **082202 Osteoporosis metabolic agents pathway**—correspondence received that pathway has been developed, and it will hopefully be available for the November 2022 CRG meeting.
1.5	**Update from GMMMG** The anticipated governance route to approval via the GM Clinical Effectiveness and Governance Committee which met for the first time in September has not materialised. The CEGC were minded to sign-off the GMMMG decisions which did not have a significant financial or commissioning impact but recognised there is no delegated authority to that group either, meaning a number of decisions are still yet to be ratified. These have been escalated to the GM ICB Finance directors for ratification. At the same meeting the issue of shared care and commissioning in GM was asked to be discussed with the GM improvement Hub who have agreed to lead on the review process. Prior to this happening a collation of feedback from the consultation will take place and this will be shared with GMMMG for a discussion regarding the next steps.
2.0 Matters arising	
2.1	**CRG Consultation August 2022**

	The only comment that was received was for **icosapent ethyl**. It was asked whether it would have a grey RAG status to mirror Omacor, permitting use only in the provisions of NICE TA805. It was noted it is significantly more expensive than Omega-3, and there is an existing NHSE positioning statement that Omega-3 should not be routinely prescribed. CRG considered applying a grey status, but it was noted that the guidance from the NICE TA805 is clear on its place in therapy, meaning an additional grey status would not be required. CRG raised the issue of affordability of NICE TAs. It was explained that CRG's role is to approve medicines for the formulary on their clinical application and would not normally consider the affordability aspect of new medicines entry to the system. If the ICB declines to provide access to medicines which have a positive recommendation in the form of a NICE TA that is a decision for the statutory body and not CRG. **Action**: RDTC to submit actions to GMMMG for approval.
3.0 Formulary and RAG	
3.1	**Formulary Amendments September 2022** CRG approved the formulary amendments to open for consultation and noted the following: • TA824: Dexamethasone intravitreal implant for treating diabetic macular oedema—links are to be replaced (TA349 removed, TA824 added). • TA825: Avacopan for treating severe active granulomatosis with polyangiitis or microscopic polyangiitis—this is to be added as a RED drug with a link to TA825. • TA829: Upadacitinib for treating active ankylosing spondylitis—this is to be added as a RED drug with a link to TA827, and it was noted there is also a pathway in development that should encompass this medication and TA. • DSU: Methylphenidate long-acting (modified-release) preparations: caution if switching between products due to differences in formulations—this will be added as a link in chapter 4.4 of the formulary. **Action**: RDTC to open formulary amendments for GMMMG consultation
3.2	**Estradiol and Testosterone for gender dysphoria (RAG Review)** Dr Luke Wookey joined (GP) for this item **(GP & Clinical Lead for the Indigo Gender Service)** *It was noted that this item on the agenda was mistakenly stated in the agenda as being just for estradiol RAG review, and clarified that this request is for both estradiol and testosterone products.* This proposal is to review the RAG status of estradiol and testosterone for use in gender dysphoria, with an aim to move from Amber Shared Care to Green (Specialist Advice). It was noted there is precedent in other areas such as the North East where these items are Green. Proposed benefits include reducing the burden on primary care (of documentation / administrative work), aiding in the recognition of the safety of hormone therapy, and normalising prescribing for trans health. The GnRH analogues are to remain as amber shared care. In the last twelve months, 258 shared care recommendations have been sent to primary care, and there has been a rejection rate of 12%. Recently, there were zero rejections in August 2022 and only one in September 2022. Currently Indigo maintains the prescribing of approx. 10 prescriptions per month, and they will retain prescribing in exceptional circumstances where GPs are unwilling or unable to prescribe medication even if it is a Green (Specialist Advice) medication as requested.

	It was noted that patients stay under the care of the Indigo Gender Service for a minimum of 18 months after starting hormone therapy, and longer if they are undergoing reassignment surgery. If there are problems or queries, GPs can refer urgently for advice, guidance, and request reviews, even if the patient has been discharged by Indigo, and this happens currently with patients who have been discharged from other services. Regular reviews are undertaken by Indigo, and treatment plans make clear the aims of treatment and the monitoring requirements are made clear. It was clarified that this change in RAG status would applicable mainly to patients under the care of Indigo service but would include patients under other NHS funded services as they should be all providing a service under the same NHSE Service Specification. It was noted that there may be some GPs who are less comfortable with the management of the condition though the expectation from NHSE commissioners and Indigo is that GPs manage trans health long term with specialist support as outlined above. CRG were happy to recommend a change to the RAG status and acknowledged the excellent support and communication received to date from the Indigo service. In the absence of a shared care protocol there was general consensus that some GMMMG-endorsed, published advice on best practice for the management of transgender patients would be helpful. **Decision**: **Approved to open for consultation for a change to Green (Specialist Advice) for testosterone and estradiol products when used under the advice of the Indigo service for gender dysphoria.**
3.3	**Dexcom One Formulary Application** Dexcom One is a real-time continuous glucose monitoring (rtCGM) device, similar in function to Freestyle Libre 1 and Freestyle Libre 2 though with the addition of a Bluetooth sensor that transmits to a device, and does not require the use of near-field communication (NFC) to scan glucose readings.. The place in therapy is the same, and it is proposed that Dexcom One is positioned alongside Freestyle Libre for use in the Greater Manchester area. There is no work at present that compares Dexcom One to other rtCGM devices. Patient choice of available sensors was highlighted as being important. The application is for use as per the recommendations on isCGM and rtCGM within NICE NG17, NG18 and NG28. The request is to position Dexcom One as an alternative CGM device alongside FSL2 for patients whom following a conversation with their prescriber believe this would be a better option. The patient groups for whom FSL and Dexcom One would be appropriate are the same, so there is no financial implications to the request. It was noted GMMMG is looking at the cost implications of implementing the above NICE guidance, and this piece of work is soon to be formally approved. One potential issue with Dexcom One is that the sensor requires an external transmitter to be connected, and this needs to be replaced three-monthly. The mechanism for this replacement is not straightforward as it is not available on prescription but direct from community pharmacy/specialist clinic with the prescribed sensors. This relies on them being ordered form wholesalers by the dispensing organisation. Manufacturers are committed to making this as simple as possible but may cause issues for unfamiliar dispensing sites. The NICE NG28 caveats use of rtCGM devices for type 2 diabetes mellitus (T2DM), and it was highlighted that this proposal appears to allow use for *all* patients with diabetes. It was clarified that the intention is to use alongside existing products, i.e., Dexcom One will have a similar place in GM to other rtCGM devices, including Freestyle Libre devices Other devices are available via FP10

	prescribing; Glucomen Day® and GlucoRx Aidex™, however these are not currently approved for use in GM. **Decision**: Approved to open for consultation to be positioned as an alternative product alongside FSL, for patients who meet the criteria in NICE CG17, CG18 and NG28.
3.4	**Metolazone (Xaqua®) RAG Review** Xaqua® is a newly licensed metolazone product, and the main difference between it and the unlicensed oral formulations currently availability is there is a suggestion that Xaqua® has a bioavailability of up to twice that of other (unlicensed) products. Currently, metolazone is in the formulary as a Green (Specialist Initiation) item, but refers to the unlicensed preparation. This proposal does not include a change of RAG status, but the replacement of unlicensed products with Xaqua; the group was happy to maintain the RAG status for Xaqua. Currently there are around 90 patients per year receiving metolazone in primary care in the Greater Manchester area, and it was asked how CRG think these patients should be managed. There are options to: switch to half-dose Xaqua and monitor, use an alternative diuretic, or seek specialist advice for each patient. It was agreed by the group that specialist advice would be most suitable for several reasons. Firstly, the bioavailability may differ between patients and there is a risk of underdosing unwell patients with standard 2:1 swaps as well as causing unnecessary diuresis. Secondly, it was suggested that as metolazone is specialist *initiation*, all patients starting a new therapy (including a new preparation with different pharmacokinetics) should be overseen by a specialist. Thirdly, this ensures alignment with secondary (and tertiary) care practices for metolazone use by involving specialists in primary care decision making. Ultimately the decision should be made on an individual patient basis and initiating a review for each patient was thought to be the most appropriate way of addressing this. The risk of brand changes was highlighted, though acknowledged the risk is lower now the unlicensed products will need to be ordered on a named-patient basis. It was suggested (and agreed) that brand name prescribing is preferable to mitigate against inadvertent prescribing and dispensing of the wrong product DN would contact LPC with outcome of this discussion and ensure contractors are made aware of product change. MO teams should seek to identify patients who are prescribed metolazone and initiate a review, FA agreed to take this action to the MO leads meeting. **Decision**: Metolazone formulary entry to be changed to Xaqua® and to recommended prescribing and dispensing is done by brand name. **Action**: DN to communicate with LPC and FA to discuss with GM MO Leads
3.5	**Chloral hydrate/betaine RAG Review** This request has come from the Oldham Medicines Optimisation (MO) team who have identified long-term prescribing of chloral hydrate for paediatric patients that is not in line with MHRA advice. They are asking that there is GM-wide support to tackle this safety issue by moving chloral hydrate/betaine to RED in the formulary so prescribing cannot be passed to primary care. They have had confirmation from local paediatricians that they would support management in their specialist clinics. Such a change would then require primary care input to identify patients and refer back to specialist teams. It was noted that this is a high-risk medication, especially in paediatric patients, and especially in long-term use. It was highlighted that GMMMG formulary and RAG status typically only apply to decisions made *after* the GMMMG approval date and asked whether it needs clarifying this applies to all patients. It

	was agreed this decision should be for all patients, not just new initiations due to the safety aspects. Whilst it was acknowledged there may be some push-back because of this decision applying to all existing patients, it was also recognised that the inappropriateness of long-term paediatric prescribing of choral hydrate cannot be mitigated by established prescribing for individual patients. **Decision**: Chloral hydrate/betaine to move to RED on formulary, and patients currently established on therapy to be referred back to specialist for prescribing and management. This will open for GM-wide consultation.
3.6	**RDTC Formulary Application Proposal** The piece of work has arisen following a request for Ogluo® (glucagon) to be considered for the GMMMG formulary. Whilst a local application was requested using the pre-approved forms, it was asked if the RDTC could create a formulary application as they were in the process of reviewing Ogluo at the time of enquiry. Historically, if a request had been raised for an item that was not part of the NICE TA, then the proposer(s) needed to complete a formulary application tool. The intention here is that the RDTC would create formulary applications and approach specialists for support for medications identified during horizon scanning and from work with other regional groups. The focus would be on items that are not in the NICE Planner, for which no decision is expected within six months, and/or if there are significant commissioning impacts expected or safety concerns with the medication (or alternative). It was noted that the current process enables pharmaceutical representatives complete forms for specialist sign-off prior to their submission to CRG. It was also noted that the RDTC currently may undertake a role of re-writing applications for submission to CRG. This does not remove the ability for GMMMG stakeholders to complete an application if they wish to submit to CRG for consideration. **Decision**: CRG approved the change to established process and agreed that a formulary application is not always required for CRG to consider a new medicine for addition to the formulary.
4.0 Pathways and Clinical Guidelines	
4.1	**HRT Guidance** *This item deferred to November 2022 CRG meeting. Late comments have been received that were unable to be considered before the meeting. KO has asked if there are any comments on the draft that is currently available then to contact her directly with feedback.*
4.2	**Asthma Inhaler Guide** This guide was presented to the September 2022 CRG meeting, and there were minor outstanding changes. This guide was intended to be approved following changes by Chair's action, though the Chair is now out-of-office, so it has been returned to CRG for approval. It was noted there is parallel work with the net-zero group, and noted that if QR codes need to be changed in future this will be done as a technical update. **Decision:** Approved to be published.
4.3	**Modafinil information leaflet for primary care**

	This information leaflet has previously been presented to CRG and external comments have been received. Changes include removal of information about "urgent referrals" as the patients will not have been discharged (and so do not need referred back), changing instead to clarify it is for "urgent advice". Queries were also raised regarding specialist supervision of lack of efficacy and pregnancy, and it was agreed this needs clarified in the information leaflet, i.e., that specialists retain oversight long-term. *Post meeting note: The Neurology service at NCA have confirmed the patients will remain under specialist oversight as agreed at February 2022 CRG meeting* **Decision**: Approved for publication.
5.0 Shared care	
5.1	**Potassium Binders SCP (Patiromer and Sodium Zirconium Cyclosilicate)** CRG previously considered this item and decided that Amber Shared Care was appropriate for the formulary. Prior versions of these documents were bought to the July 2022 CRG meeting and then were opened for consultation. Following points raised in this consultation process, these documents have been updated further. It was highlighted that these items are currently being prescribed in all areas of Greater Manchester at present and have positive NICE Technology Appraisals. **Decision:** Approved to go to GMMMG for ratification. **Action**: AMa to circulate consultation feedback and draft changes to group.
5.2	**GM Shared Care Update** *There was no standalone update to this item, beyond the information covered in item 1.5.*
6.0 Work plan and horizon scanning	
6.1	**Horizon scanning September 2022** CRG noted the contents of the document, and two items were discussed. **1. Betula pendula Roth, Betula pubescens Ehrh** It was asked if this item, derived from birch bark, needs to be reviewed. It was suggested it may be worthwhile liaising with dermatologists as it is unclear if this would be a cost saving compared to existing wound formulary options. RDTC are scoping a formulary assessment tool to support the evaluation of this product. **2. Faecal microbiota transplant for recurrent Clostridioides difficile infection** The route for comments on this item would be via the GM Antimicrobial steering group for addition to the guideline if appropriate.
7.0 AOB	
1.	**GMMMG Formulary Chapter 4 – First Generation Typical Antipsychotics** It was noted that first generation typical antipsychotics do not appear in the formulary. It was clarified that they do appear for palliative care use and as depot injections. It was also noted that first generation typical antipsychotics are no longer routinely used and this is likely why this is reflected in the formulary. It was noted that there have been a few instances within the Greater Manchester area where GPs are refusing to continue antipsychotics started in secondary care as

they are not listed on the formulary. A formulary application would be required to amend the formulary status, but it was noted this has been discussed a number of times in the past without success.

2. Andrew White noted that this is likely his last CRG meeting as he is moving to a new role as the Chief Pharmacist for the Lancashire and South Cumbria ICS at the end of October 2022. CRG thanked him for his valuable support over the years and wished him well in his new job.
3. **GLP-1 Agonist Shortage**

   There is a shortage of Ozempic 1mg solution for injection (semaglutide) and Trulicity 0.75mg, 1.5mg, 3mg, 4.5mg solutions for injection (dulaglutide) until the end of October 2022. Whilst some stock is expected before the end of October, this is likely to be sufficient to support existing patients only, and that this is unliely to change until January 2023 at the earliest. It was highlighted that the SPS lists suggested alternatives and a publication from the Primary Care Diabetes Society can be used to support primary care decisions. Oral therapy may be suitable for some patients until GLP-1 agonists can be initiated once again.

Date of next meeting: Tuesday 8th November 2022 12:00-14:00 via Teams