Minutes of the GMMMG Clinical Reference Group Meeting Tuesday December 13th, 2022, 12:00-14:00 via MS Teams

Name	Title	Organisation	July	Aug	Sept	Oct	Nov	Dec
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	✓	✓	✓	✓
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	A
Andrea Marrosu (AM)	High-cost Medicines and Home Care Pharmacist	Salford Royal FT	✓	✓	✓	A	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 (MC)	A	A (MC)	A	A (MC)	MC
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	✓	A	✓	✓	✓	✓
Steven Buckley (SB)	Director of Pharmacy	GM Mental Health FT	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 Neighbourhood Integrated Practice Pharmacists	Salford Royal FT	✓	A	A	✓	✓	✓
Claire Foster (CF)	Senior Medicines Optimisation Adviser	NHS GM IC (Manchester)	✓	✓	✓	✓	A (ZP)	✓
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	LL	LL
Consultant Rheumatologist Audrey Low Ben Parker Charlie Filer Dipak Roy Louise Mercer		SRFT MFT Stockport TGH Stockport	A	✓ SN	A	✓ (SW)	✓ (AL)	✓ AP

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

1. General Business	
1.1	**Welcome and apologies** In attendance were Anna Pracz and Elaine Radcliffe from GM ICB to facilitate presentation of items 4.1 and 4.3 respectively
1.2	**Declarations of interest** Previously declared where relevant. No further declarations of interest were made.
1.3	**Draft November 2022 CRG Minutes** The November 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: • The osteoporosis pathway needs further work on patient numbers and costings. Discussion with NOGG guideline authors has highlighted that no economic modelling was conducted for their work. Because the NOGG guidance seeks to prioritise romosozumab use and increase availability of teriparatide out with NICE TAs, assurance that this use of the medicine is cost-effective is required. • CRG heard that Health Innovation Manchester are looking at introducing tirzepatide to the GM system in advance of the NICE TA being published (due April 2023). CRG wished to ensure that the formulary does not recommend prescribing prior to a TA being published.
1.5	**Update from GMMMG** None provided
2.0 Matters arising	
2.1	**CRG Consultation October 2022** This consultation has received the most comments of any GMMMG consultation, the majority relating to the proposed RAG change of oestrogen and testosterone when used to manage gender dysphoria in patients aged 17 years or over, from Amber to Green specialist advice. The 22 comments were unanimously and strongly against making any amendments to the RAG. The themes include inappropriate transfer of workload from specialist to primary care, a lack of skills and expertise within primary care to manage these patients and the medico-legal implications

	of prescribing for transgender patients without the support of a specialist service, all of which would contribute to a poorer service for patients. **CRG will not seek to amend the RAG status for these medicines.** The committee also heard that the service is shortly to be retendered and an expressions of interest period has recently closed. Given the strength of opinion received through the consultation GMMMG will seek to influence the service spec for subsequent providers to ensure there is facility for prescribing of medicines included from the specialist service. **Post meeting note –** The service being tendered is in fact the national paediatric service which has been decommissioned from the Tavistock and Portman Trust, for which it has been reported that a consortia of North West FTs have expressed an interest in providing. This is not relevant to the Indigo service in GM **Action:** DN to liaise with commissioners to facilitate this discussion. **Dexcom One** CRG proposed that this device should sit alongside FreeStyle Libre as an option for CGM in line with NICE recommendations which are currently formally being adopted by the ICB through GMMMG's governance process. The comments were in favour of adoption and agreed that this would provide appropriate choice for patients. Some comments requested caution on the impact that this may have on community pharmacy and that guidance is needed for primary care on appropriate use including where readers can be obtained, that patients must still be prescribed BGTS and lancets, and that Dexcom One does not have the same functionality as typical rtCGM devices for use with closed-loop insulin pumps. CRG did not assign a RAG because this has not previously been done for FSL. **CRG will produce guidance on the use of Dexcom One for primary care** **Chloral products** CRG proposed a RED status for all forms of these medicines in line with recent MHRA guidance regarding the safety of long-term use. There was useful feedback from neurologists that there are circumstances where long term use may be appropriate such as movement disorders and palliative care. It was clearly articulated by respondents that a RED hospital only status could be detrimental to patients seen by GM services but who live outside the region, these patients would then be forced to travel to collect prescriptions. CRG heard that the current situation whereby secondary care prescribers cannot use electronic transfer of prescriptions (eTP - currently being considered nationally for roll out to secondary care) is proving to be a barrier to safe and appropriate prescribing and is adding to the workload of primary care. It is understood FP10HP prescribing is tightly controlled in secondary care and that electronic prescribing systems are not set up to enable eTP at present. Given the gap between what CRG felt was safe and what was currently possible, this action has been paused**.** **Action:** Primary care MO teams are asked to audit chloral hydrate/betaine use to better understand the scope of the problem. RDTC will look to obtain this data from the BSA. **The remaining actions proposed were approved.**

	Action: as above plus RDTC to submit actions to GMMMG for approval.
3.0 Formulary and RAG	
3.1	**Formulary Amendments November 2022** CRG approved the formulary amendments to open for consultation and noted the following: • There were no NICE TAs completed and published in November 2022. All were terminated appraisals • A single recommendation to add Cyclogest pessaries to the formulary for the indication of prevention of miscarriage and place as first line was agreed. **Action: RDTC to open formulary amendments for GMMMG consultation**
3.2	**Typical (first generation antipsychotics) RAG review** A RAG review of oral first generation antipsychotics, haloperidol, zuclopentixol, flupentixol and sulpiride was presented and a RAG status of green was requested for the indications of schizophrenia/psychosis. CRG heard that these medicines currently have no formulary or RAG status with the exception of haloperidol for palliative care use. The lack of RAG status makes it difficult to transfer prescribing to primary care and this is only being done where individual GPs are happy to take on prescribing. NICE do not differentiate between the first and second generation oral antipsychotics and monitoring is similar but there are differences in side effect profiles. CRG believed there should be consistency in RAG with the atypical oral antipsychotics, therefore either all oral antipsychotics are Amber shared care or all are Green specialist initiation/advice. The discussion moved on to what was good practice in other areas where these medicines are Green specialist initiation/advice and that stable patients are routinely discharged from services with a comprehensive care plan and access back to specialist review if required. CRG noted the historic differences in mental health service provision across GM and that access to a specialist can be difficult. This is what shared care appears to be being used for in the majority of GM areas, although some localities do have a step-down model of care in place with discharge to GP when stable and a rapid access route back in to MH services and others are working towards this. The GM improvement Hub are taking on the review of some aspects of shared care, and although the scope of the work is not yet clear, it was suggested that mental health shared care could be a smaller more defined piece of work to begin with. It was suggested by the requesting organisation that this review requires a bigger piece of work to be undertaken looking at all oral antipsychotics and that there is no immediate need to amend the RAG. **Decision**: No change to RAG agreed. This topic will be revisited at a later date.
3.3	**Drugs for dementia - RAG review** There is some discrepancy with RAG status for the 3 acetylcholinesterase inhibitors and memantine for dementia treatment. The formulary and RAG state Green following a discussion by FMESG in 2018 after the publication of NG97, but the GP prescribing leaflets on the GM website still state Green specialist initiation. Given the statements contained in NG97 regarding the criteria on which NICE recommend the medicines are started and that the first prescription may be made in primary care, a status of Green specialist advice seems appropriate.

	Decision: CRG recommend Green specialist advice **Action**: RDTC to conduct technical update on the prescribing information documents hosted on GMMMG website
3.4	**Modafinil for MS – RAG review** A request has been made for modafinil when used for treating MS symptoms, to be Green specialist initiation in line with the RAG for Parkinson's disease and narcolepsy. CRG noted that this is an off-label indication but is recommended by NICE as a treatment option (as is PD), however NICE do state in NG220 that when the person is on stable dose of medicine for fatigue this may be issued under s shared care agreement. Following a discussion about the merits of shared care it was agreed to propose a Green specialist initiation in line with the other indications on the formulary. This is because the RMOC definition of shared care requires significant ongoing monitoring for which there is none for modafinil and also that patients will remain under specialist for the management of their condition. **Decision**: CRG propose Green specialist initiation pending further information on patient numbers from the services.
4.0 Pathways and Clinical Guidelines	
4.1	**Rheumatology HCD pathways** 3 updated pathways were presented for clinical approval from CRG these are for rheumatoid arthritis, psoriatic arthritis and axial spondylarthritis. These have been updated in line with recent British Society of Rheumatology guidance on pregnancy and lactation, have included all published NICE TAs and align with the RMOC statement on sequential use of biologics. These have undergone consultation and the comments have been incorporated as appropriate. To improve healthcare efficiency and patient experience, the pathways now suggest that rheumatology clinicians may prescribe alternative regimens of high cost drugs, where advice from specialist has been requested, received and documented and provided that it is covered by relevant GMMMG pathway (e.g., IBD, psoriasis). **Post-meeting amendment:** Following CRG it has been decided by the pathway authors to remove the recommendation above regarding use of biologic medicines in other HCD pathways. Whilst this was recognised to be a credible recommendation, more work is required in order to implement and it is therefore withdrawn pending inclusion in a future HCD pathway update. **Decision:** CRG were happy to recommend the documents be approved by GMMMG
4.2	**Polypharmacy resource pack** CRG approved a technical update to this resource and recommended that future updates may be conducted every 2 years or sooner if significant guidance is published that warrants an update. **Decision:** CRG were happy to recommend the document be approved by GMMMG
4.3	**GM Antimicrobial Guidelines - Update** This update seeks approval for a number of amendments in line with NICE, to address concerns about local resistance and revise the recommendations for treating Strep A. A further revision to NICE Strep A and scarlet fever guidance is expected imminently. This will be added in a future update **Decision**: CRG were happy to recommend the document be approved by GMMMG

4.4	**GM Cancer Alliance: Toolkit for risk reducing endocrine therapy for women at moderate and high risk of breast cancer** CRG recognised the requirement of the project to manage breast cancer risks in the GM population and were very supporting of the documents intent and content. A query was raised regarding the recommendation to GPs on the use of anastrozole which askes primary care to arrange a bone densitometry scan within 3 months of the medicine being started. CRG noted that the patient is scheduled to see the specialist at 3 months and to prevent the possibility of this being missed or delayed. **Decision**: CRG were happy to support this work but requested clarity on governance routes.
5.0 Shared care	
5.1	**Oral atypical antipsychotics SCP** CRG considered an update to the document that was presented to CRG at their November meeting. Some minor amendments had been made following discussion with primary care to address the concerns regarding antipsychotic use in dementia. Further clarification regarding section 3 was suggested and approved as well as a request to ensure all unlicensed use is captured as recommended by NICE **Decision** CRG approved the document with the suggested amendments **Action**: GMMMG have pre-approved the financial impact of this document. Overall approval will now be sought from CEGC
5.2	**GM Shared Care Update** *There was no standalone update to this item.*
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning November 2022** CRG noted the contents of the document, and the following items were discussed. 1. Tirzepatide – the potential impact noted as discussed earlier in the meeting 2. Sitagliptin – the large financial impact associated with generic savings is yet to be realised due to drug tariff prices remaining high.

7.0 AOB

1. A query about the RAG status of budesonide orodispersible tablets was raised. This will be clarified on the RAG list.
2. The MHRA have updated their recommendations on valproate on 12th December 2022. This now recommends that in particular that 2 specialists should independently consider and document that there is no other effective or tolerated treatment for patients aged under 55 years. Valproate: reminder of current Pregnancy Prevention Programme requirements; information on new safety measures to be introduced in the coming months - GOV.UK (www.gov.uk)

Date of next meeting: Tuesday 10th January 2023 12:00-14:00 via Teams