Minutes of the GMMMG Clinical Reference Group Meeting
Tuesday April 18th, 2023, 12:00-14:00
via MS Teams

Name	Title	Organisation	Sept	Oct	Nov	Dec	Feb	Apr
Dr Peter Budden (PB) Chair	GP	St Andrews Medical Practice	✓	A	✓	✓	✓	✓
Dr Helen Burgess (HB)	GP	NHS GM IC (Manchester)	✓	✓	✓	A	✓	✓
Dr Jonathan Schofield (JS)	Consultant Physician Acute Medicine & Diabetes	Manchester FT	✓	✓	✓	✓	✓	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	NHS GM IC (Heywood, Middleton & Rochdale)	A (MC)	A	A (MC)	MC	A	MC
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	✓	✓	✓	✓	✓	✓
Steven Buckley (SB)	Director of Pharmacy	GM Mental Health FT	✓	✓	✓	✓	ML	ML
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	A
Jennifer Bartlett (JB)	Team Leader Neighbourhood Integrated Practice Pharmacists	Salford Royal FT	A	✓	✓	✓	A	A
Claire Foster (CF)	Senior Medicines Optimisation Adviser	NHS GM IC (Manchester)	✓	✓	A (ZP)	✓	IH	✓
Jole Hannan (JH)	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	✓	LL	LL	LL	LL	LL
Consultant Rheumatologist Audrey Low Ben Parker Charlie Filer Dipak Roy Louise Mercer		SRFT MFT Stockport TGH Stockport	A	✓ (SW)	✓ (AL)	✓ AP	A	A

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	✓	✓				
Andrew White (AW)	Head of Medicines Optimisation	NHS GM IC	✓	✓				
Andrew Martin (AMart)	Strategic Medicines Optimisation Pharmacist	NHS GM IC	✓	✓	✓	✓	✓	✓
Karina Osowska (KO)	Medicines Optimisation Pharmacist	NHS GM IC	A	✓	✓	✓	✓	A

1. General Business	
1.1	**Welcome and apologies** In attendance were; Dr Aseem Mishra; GPST3 and GM Strategic Clinical Network CVD Lead to present item 4.6, Anna Pracz (GM IC Central team) and Maxine Wright, RDTC to observe the meeting
1.2	**Declarations of interest** Previously declared where relevant. No further declarations of interest were made.
1.3	**Draft February 2023 CRG Minutes** No meeting was held in March. The minutes were approved for publication to the GMMMG website
1.4	**Action log review** The owner of each action will be approached for updates if not already provided to CRG. Some items have full agenda items. Others have progress as follows: • Ogluo: Dr Doughty at RMCH has withdrawn the application for Ogluo, this action is now closed until a further formulary request is made • Choral products: need data from other localities to progress this work • Levetiracetam: This was due to be discussed by the GMMMG medicines value subgroup, unfortunately their meeting this month has been cancelled. A workstream lead is still required to progress this. • Shared care for lithium – AP explained this work is paused at present awaiting further information from NHSE medicines policy team on the local requirements for adoption/implementation of the national SCPs. It was noted that the monitoring requirements for cluster headache are the same as for the mental health indications although with less emphasis on maintaining a therapeutic range. CRG asked if the routes of escalation to non-mental health specialist services could be included in the document when work is resumed.
2.0 Matters arising	
2.1	**CRG Consultation February 2022** The comments submitted through consultation were noted and discussed. All were supportive of the actions so CRG went on to consider the requests received through this process for further resources and/or actions associated with certain decisions.

	CRG did not believe there was a requirement for resources to support the metformin 1g tablet switch. MO teams work to date shows this prescribing was likely due to picking errors when the intended product was either 500mg immediate release or the 1g MR form. A relevant issue was raised regarding assurance that prescribers adhere to the DNP and Grey lists and how this can be monitored. The grey list is hard to provide assurance against in the same way that a DNP report can identify non-adherence, this is because epact prescribing data does not provide indication for prescribing. However a role for CRG in the discussion of interface issues could be considered. **The actions proposed were approved.** **Action**: RDTC to submit all actions to GMMMG for approval.
3.0 Formulary and RAG	
3.1	**Formulary Amendments March 2023** CRG approved the formulary amendments to open for consultation and noted the following: • TA875 Semaglutide for managing overweight and obesity. CRG agreed with a RED status noting that this does not necessarily restrict prescribing to secondary care based services but facilitates any specialist to issue prescriptions whilst discouraging non-specialists from prescribing. The group recognised that there is unlikely to be sufficient service capacity currently commissioned within the GM ICS to facilitate access in line with the NICE recommendations and asked that this discussion be escalated as the medicine is considered for approval in GM. **Action: RDTC to open formulary amendments for GMMMG consultation**
3.2	**Hydrocortisone modified (Efmody) for CAH in patients aged over 12 years** A request to add Efmody to the formulary for patients with congenital adrenal hyperplasia (CAH) whose condition is not controlled on standard release hydrocortisone, was considered. It is estimated that the Paediatric Endocrinology team at RMCH see around 10 patients per year from the North West region who would benefit from this medicine. The request is to restrict treatment as a second line option for those for who are developing testicular adrenal cell rests, or have an excess glucocorticoid burden, and in adolescents where there is concern about poor compliance, growth, pubertal development or excess virilisation. It will replace immediate-release hydrocortisone in these patients with the exception of periods of intercurrent illness when standard hydrocortisone will be used as per usual sick day rules. CRG looked at decisions made elsewhere and noted the SMC and AWMSG decisions were apparently contradictory. The SMC considered all CAH patients and concluded that there was no benefit over standard therapy, however the AWMSG looked at a similar group of patients to those proposed here, who had not responded to standard treatment and agreed use was appropriate and cost-effective. A letter to primary care is in development by MFT to support the transfer of prescribing of this medicine. **Decision**: CRG agreed with the application and the request to assign a Green Specialist initiation status and will open the recommendation for consultation.
3.3	**Formulary assessment tool - tacalcitol**

	A review of this medicine undertaken by RDTC has shown that there is limited evidence for its efficacy in the treatment of psoriasis, and that evidence which is available shows it is significantly less effective than existing therapy. A discussion was held regarding the current cost of calcipotriol scalp solution which should not be used as a first line option for psoriasis according to NICE CG153 and should be reserved as a third line treatment for when the patient cannot use corticosteroids. **Decision**: Tacalcitol (Curatoderm) ointment and lotion did not reach the threshold for addition to the GMMMG formulary. Open for consultation as non-formulary
3.4	**Paediatric RAG review – dapagliflozin for CKD** CRG accepted the RED RAG status proposed for dapagliflozin for CKD stage 2-3 in post-pubescent children **Decision**: Open proposed RED RAG status for consultation
4.0 Pathways and Clinical Guidelines	
4.1	**Azithromycin guidance for chronic respiratory conditions** A review of long-term azithromycin prescribing in the Bury locality, pre-pandemic, identified that primary care are frequently prescribing this medicine without adequate monitoring or follow-up. The audit showed that there are 3 indications for which it is used; COPD, asthma, and bronchiectasis, all of which are supported by guidance and were initiated by specialists. The audit also showed that some patients were taking sub therapeutic doses or had been discharged from their specialist without a management plan. Local guidance was therefore developed in conjunction with GP and respiratory specialist representation to support safe prescribing of the medicine in primary care. Following this a reaudit was undertaken to check that guidance was still required. The guidance, initially intended to be implemented in the Bury locality did not gain local approval, due to the reorganisation of governance structures into the Northern Care Alliance organisation, and was therefore taken to the GM antimicrobial steering group who supported the document and suggested GMMMG as the mechanism for adoption across the GM ICS. CRG acknowledged the frequent poor management of long term azithromycin in primary care and welcomed the guidance, particularly the advice on cessation of therapy. The RAG status assigned should reflect that this is a specialist indication but that the ongoing specialist involvement would be limited and therefore shared care did not seem appropriate. A Green specialist advice RAG was proposed and agreed. The group acknowledged that there may be local differences in management and that this may differ depending on indication e.g. bronchiectasis patients may remain under long term follow up from the specialist clinician. **Decision:** Open guidance and RAG for consultation – With specific questions requesting information on local procedures for managing these patients
4.2	**GM Antimicrobial Guideline update** ER presented an updated GM antimicrobial guideline with the following amendments: • The acute sore throat section was reinstated after the retirement of national strep A guidance in Feb 2023 and erythromycin has now been included as an option for penicillin-sensitive pregnant patients.

	• Scarlet fever section reinstated after the retirement of national strep A guidance in Feb 2023 • Some wording amendments to the influenza section to remove reference to the GM influenza outbreak guidance which has now expired • GM use amoxicillin in preference to pen V in acute sinusitis. The wording has been reintroduced to explain this local deviation from NICE • Pivmecillinam has been included as an alternative option for lower UTI treatment in non-pregnant patients. This cannot be used as a first line treatment because the laboratory sensitivities assay does not include this agent as standard. Some discussion was also held on the RAG for fosfomycin, ER will confirm if this needs to change and complete a RAG review form if necessary. **Decision** CRG noted the amendments and approved the updated guidance for publication
4.3	**Drugs for dementia – primary care info leaflets review** A suite of 4 leaflets designed to support prescribing of dementia medicines in primary care was presented to CRG. These are updates to existing out of date versions and the review included updates to the cautions, contraindications, and interactions sections, as well as updated information on general anaesthetics. CRG pointed out that the sections on specialist responsibilities were not clear and do not reflect current practice. **Decision** Amend the first 3 paragraphs of each document to reflect specialist and GP collaboration with titration prior to discharge from the specialist service. These should return to CRG for approval before publication
4.4	**COPD inhaler guide** The update to include the new Trixeo inhaler device image was approved **Decision** Publish to website
4.5	**GMMMG HCD pathways – technical updates to AS & PsA pathways** AP informed the group that some minor changes to the PsA and AS pathways were required after some inaccuracies were identified after publication. **Decision** CRG approved the amended documents for publication to the website
4.6	**GM SCN hypertension pathway** This item was taken at the top of the agenda to enable Dr Mishra to resume clinical duties. Dr Mishra explained that CVD is a leading cause of disability in GM, which is worsened by deprivation, hence this is a system-wide problem that needs to be addressed and as such is included in the ICS and national priorities. It is estimated that eliminating hypertension would lead to a 8% reduction in mortality, which is greater than the effect of eradicating tobacco smoking. A pilot scheme in Stockport shows that by increasing the speed of establishing control of BP it is possible to achieve higher rates of normotension, this may counteract the change fatigue that some patients experience with frequent medicine titrations. Therefore the pathway presented is designed to follow NICE but to add in a second agent prior to any titration of the first antihypertensive. The development process has involved a literature review and the expertise of the SCN to draft the pathway, this clinical consensus was then further developed using a task & finish group with

	multiple stakeholders across primary and secondary care and has already undergone a small consultation process before being presented to CRG. The key points to note are; • After discussion with community pharmacy, there is a recommendation to refer to CP for ABPM • A review of recommended ACEi treatments opted for lisinopril due to the available dose range and that ramipril and perindopril, whilst widely used have problems with duration of effect and the potential for confusion regarding salt forms respectively. The SCN concluded that there was a class effect from ACEis and that lisinopril is a low cost and pragmatic choice. • The pathway adds a second drug before any titration of the first is attempted, this is due to a recognition that combination therapy is around 5x as effective at lowering BP than doubling a single agent. No single antihypertensive can reduce BP by >20mmHg so the majority of patients will require at least 2 agents. • There are educational statements within the document to provide a rationale for the prescribing recommendations • Adding a 3rd agent before titrating doses of agents 1 & 2 has been shown to be more effective but concerns over polypharmacy and pill burden has resulted in this recommendation being removed and the guidance now recommends a dose increase of the first medicine prior to this step. • There is signposting to the community pharmacy new medicines service (NMS) CRG believed the document to be a useful, and easy to follow pathway and approved it for consultation with some minor amendments; • It was noted that not all GM localities have access to community pharmacy ABPM services and the document should reflect this. • There is reference to, but no further information available on the DASH diet, could this be included with a link to more information. • The prescribing recommendations are didactic in places and may not consider the needs of certain populations, e.g. elderly and/or CKD patients who should start some medicines at a lower dose, it was suggested that this is denoted with an asterisk and description in the footer to maintain the single page summary. • A discrepancy regarding eGFR reductions with lisinopril between the flow chart and supporting information will be addressed by the authors. **Decision** With the amendments noted above, the hypertension pathway was approved for consultation
5.0 Shared care	
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning March 2023** CRG considered the contents of the document and had no comments to make.
7.0 AOB	
	• LL raised that a number of patients had required Buvidal (buprenorphine prolonged release injection) prescribing through MFT and wished to clarify its position. Coincidentally an enquiry has been received by the RDTC team on this product. It currently has no formulary status in GM, and although a number of requests have been made no formulary application has been completed. AP agreed to share the contact details of the substance misuse service lead for GM and they would then be approached for a GM position.

Date of next meeting: Tuesday 9th May 2023 12:00-14:00 via Teams