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

Name	Title	Organisation	Aug	Sept	Oct	Nov	Dec	Feb
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	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	A (MC)	A	A (MC)	MC	A
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	A	✓	✓	✓	✓	✓
Steven Buckley (SB)	Director of Pharmacy	GM Mental Health FT	A	✓	✓	✓	✓	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
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)	CCG Interface Pharmacist	NHS GM IC (Bolton)	A	✓	✓	✓	✓	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
Consultant Rheumatologist Audrey Low Ben Parker Charlie Filer Dipak Roy Louise Mercer		SRFT MFT Stockport TGH Stockport	✓ SN	A	✓ (SW)	✓ (AL)	✓ AP	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	JCT	✓	✓	✓			
Andrew Martin (AMart)	Strategic Medicines Optimisation Pharmacist	JCT	✓	✓	✓	✓	✓	✓
Karina Osowska (KO)	Medicines Optimisation Pharmacist	JCT	A	A	✓	✓	✓	✓

1. General Business	
1.1	**Welcome and apologies** In attendance were; Anna Pracz to present item 5.1, Matthew Ling from GMMH deputising for Steve Buckley, and Imran Hamid from Manchester locality of the GMICB, deputising for Claire Foster.
1.2	**Declarations of interest** Previously declared where relevant. No further declarations of interest were made.
1.3	**Draft January 2023 CRG Minutes** No meeting was held in January.
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: JS has received communication from the lead clinician for the RMCH that they believe Ogluo should be an option for all children with T1DM. Contact details have been provided, DN to follow-up. • Choral products: Bury MO team is only locality to provide audit data. A reminder has been issued to other teams to provide this information.
2.0 Matters arising	
2.1	**CRG Consultation December 2022** There were 2 respondents to this consultation, both of whom agreed with the proposed actions. Further comments were received on the order in which the dementia drugs are considered in the pathway. NICE do not make a recommendation on this except to say that treatment should be started with the lowest acquisition cost medicine (currently generic donepezil), however an alternative could be provided if the clinician thinks it appropriate. CRG believed that the NICE position made this practice difficult to challenge. **The actions proposed were approved.** **Action**: RDTC to submit actions to GMMMG for approval.
3.0 Formulary and RAG	

3.1	**Formulary Amendments January 2023** CRG approved the formulary amendments to open for consultation and noted the following: • The withdrawal of Insuman comb 50 by the manufacturer will be completed by June 2023. CRG agreed with the recommendation that the replacement first line intermediate-acting human insulin should be Humulin I (currently alternative formulary choice). **Action: RDTC to open formulary amendments for GMMMG consultation**
3.2	**RAG review – bile acid sequestrants for CV prevention in hyperlipidaemia** CRG considered the request to amend the RAG status for colesevelam and colestyramine for CVD prevention in hypercholesterolaemia. Currently only colesevelam has a RAG for this indication which is DNP, and this is causing primary care prescribers to reject the small numbers of requests to transfer the prescribing from specialists. The requesting clinicians were agreed that there is a role for these medicines when no other treatment is suitable. CRG considered the NICE "do not do recommendations" for bile acid sequestrants and their statuses in other formularies in the region, as well as the lack of good evidence for efficacy, and agreed that these medicines should not be routinely used for this indication. A Grey status (criterion 1) would be appropriate. Given the existing status of Green specialist advice for the GI indications of these drugs, there is no reason on the grounds of safety why these cannot be transferred into primary care. There is little requirement for ongoing specialist involvement or monitoring but the initial recommendation should come from a specialist lipid clinic **Decision**: Propose a Grey status (criterion 1) for patients where there is no alternative treatment option due to intolerance, or ineligibility for PCSK9i or Inclisiran treatment. With an additional RAG status of Green specialist advice.
3.3	**RAG review - Potassium permanganate** A proposal to assign a RED RAG status to potassium permanganate was heard by CRG. This is following a NPSA alert issued in April 2022 which was designed to minimise the risk of inadvertent oral administration. CRG was informed by representatives from secondary care that their D&T committees have completed the actions listed in the alert and would be happy with a RED status. The trusts represented have applied similar governance procedures to the prescribing of the medicine to only permit consultant dermatologists to initiate prescribing. The group were informed that some tissue viability teams though the product should not be prescribed at all, but that it was recognised by dermatology that there is a place in therapy, provided caution is taken to ensure prescribing is done safely **Decision**: CRG propose a RED status.
3.4	**Formulary assessment – Actimorph** A RDTC formulary assessment tool was presented for CRG to consider adding to formulary and assigning a RAG status to orosdispersible morphine sulphate tablets (Actimorph). The clinicians on the group could see a rationale for use in acute pain, particularly if there are swallowing difficulties or small doses are required for example in dose titration (either up or down) of opioid analgesia. However, its use in titration may warrant the prescribing of several different strengths to facilitate this, and could lower the risk of overdose that is sometimes associated with patients "swigging from the bottle". A potential issue regarding safe storage was discussed if this product is to replace the routine use of oramorph. Although not a schedule 2 controlled drug some sites treat morphine oral solution 10mg/5mL products as such, and others do not, therefore the increased storage requirements

	could cause a problem. CRG clarified that there was no appetite to replace the majority of use of established immediate release analgesia preparations, but that an orodispersible tablet option, available in doses from 30mg to 1mg, could be a useful option where the alternatives (e.g., oramorph/sevredol) are not suitable. There was not considered to be any significant financial implications to this proposal. A 100mg per day dose of morphine is similarly priced for both Actimorph (as 20mg tablets) and morphine sulphate oral solution 10mg/mL. Use of the 1mg tablets would be more expensive than oral solution but the advantages of lowering the risk of overdose, highlighted by the HSIB report, could be considered an appropriate use of resources. **Decision**: CRG proposed the additional of Actimorph orodispersible tablets to the formulary with a Green status. They should be placed as an alternative option where oral solution is not suitable
3.5	**Formulary assessment – trifarotene for acne** A RDTC formulary assessment tool for trifarotene (Aklief) was considered by CRG. This has been shown to be effective at reducing the appearance of facial acne but has not been compared to other products currently available. CRG discussed that the majority of acne treatment is managed in primary care and is difficult to treat, therefore an additional product that would be at no extra cost to the alternatives, some of which are unlicensed, would be welcomed. There was seen to be an additional role in reducing the use of topical antibacterials. **Decision:** Trifarotene is proposed to be added to the formulary as an additional option as a Green drug.
3.6	**iQoro device** A decision was requested on the use of the IQoro device for all its recommended indications. A number of GM localities have been receiving requests to prescribe this from patients, who appear to have been advised by gastroenterology teams to use it. CRG considered the available evidence and a guidance statement produced by the East of England Priorities Advisory Committee. The evidence for effectiveness is very poor and is undermined by the fact that the author for each trial is also the device patent holder. CRG agreed that the device did not reach the threshold for being an appropriate use of NHS resources and should not be prescribed. It is available to purchase by patients directly from the manufacturer at a cost of £145, if they still wish to use it. **Decision:** It is proposed that IQoro is added to the DNP list.
3.7	**Metformin 1g tablets – RAG proposal** CRG heard that an RDTC analysis of the prescribing of metformin immediate release tablets is resulting in an additional spend of £716k per year in GM based on current prices of the product. CRG were asked if there is any clinical rationale for the use of 1g versus 2x500mg tablets, CRG was of the opinion that there is not. It was explained that by adding to the DNP list, an action will be generated for locality MO teams to review prescribing and make appropriate switches. **Decision:** It is proposed that metformin 1g immediate tablets are added to the DNP list.
4.0 Pathways and Clinical Guidelines	
4.1	**Levetiracetam – switch to generic prescribing**

	A request for CRG to consider the potential to switch patients from Keppra to generic levetiracetam was presented to CRG. The request originates from a discussion at the GMMMG medicines value group, where analysis of prescribing shows there is the potential to save £100k per month in GM with a 100% switch. The accompanying paper highlights evidence that this switch can be done safely, and indeed has been done in many areas of the country. However, the evidence also suggests that for a small number of patients the switch can trigger seizures, the impact of which on patients and the system could be significant and should therefore not be underestimated. The request to CRG was to approve the creation of a task-and-finish group to look at the potential to place generic levetiracetam as first line and to explore the possibility of undertaking a safe switch to generic. CRG agreed that it is imperative that this is led by specialist clinicians to create a GM-consensus, without which the work is unlikely to be fully and universally implemented. Some barriers to this work in the past were cited as being specialist paediatric nursing teams, and the cost of products, it is therefore important to ensure representation from trust procurement and paeds nursing. **Decision:** CRG approved the creation of a task and finish group to report back to CRG.
5.0 Shared care	
5.1	**Adoption of the national shared care protocols** The first 4 shared care protocols, adapted from the national template were shared with CRG for approval. There were 5 on the agenda, however a late request for more time to consider the leflunomide document has resulted in that being deferred to a future meeting. The template used has been updated following the comments received from CRG members through the January approval process, this was for information. KO outlined the process undertaken to date, which includes both a national and regional consultation, the comments from each have been incorporated at various stages. Over 190 were received from 14 GM organisations in their ICS-wide consultation. It was explained that a GM-wide task-and-finish group is being set up to review the non-clinical comments and to develop a sustainable model for GM shared care. This group is due to meet in March. Meanwhile, in preparedness for the outcome of these discussions, the national protocols are being adapted for GM use. Priority is given to those SCPs most out of date. The process for review and update of the SCP documents, which includes review against the corresponding GM SCPs, current summaries of product characteristics, safety alerts, relevant guidance and GM formulary and RAG list. The 2022 GM consultation comments were screened for relevance. Any previous local consultation comments for SCP updates were considered where available. The four documents tabled for adoption are: • Azathioprine and mercaptopurine: • Ciclosporin • Lithium • Hydroxycarbamide All SCPS include an expansion of the indications for which shared care is appropriate. CRG agreed that indications currently not approved for shared care would be discarded from each document until such a time as a review was requested by the relevant specialist services.

	A discussion also took place about the inclusion of all available products in each SCP as the national documents list all that are in the BNF. This was especially important for medicines such as lithium and ciclosporin where maintaining patients on a particular brand is recommended. An agreement was reached to clearly note which products are the preferred option as per GM formulary but also list others that may be appropriate for use in exceptional circumstances. This would not require the formulary to be amended. The "model B" process that is used in some parts of GM is not reflected in the national documents. This is because a decision was taken that only the "model A" of shared care was recognised as an appropriate standard for transferring medicines into primary care. CRG understood that those areas in GM which still employ this model are in the process of transitioning to the nationally accepted model. Medicine specific discussions took place regarding: Azathioprine and mercaptopurine: indications added from the list of national ones are those for dermatology and neurology. This is because these were already in the process of being included within the GM SCPs during a scheduled review, until the systems were asked to stop due to the development of national documents. • Lithium: cluster headache was added as a locally approved indication following work done to develop a GM headache pathway. Similar to AZA/6-MP this update was due for inclusion in GM but was paused when the national process overtook the local one. Confirmation on therapeutic levels and monitoring requirements for this indication was requested from the specialist service. **Decision** Pending the amendments requested the SCPs were approved by CRG **Action**: AP/KO to make amendments and submit to RDTC for approval by GMMMG
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning January 2023** CRG considered the contents of the document, and the following items were noted. 1. Nicorette mouth spray
7.0 AOB Two items were raised, the cardiometabolic renal pathway for T2DM which is awaiting work being done by RDTC to estimate the financial impact and tirzepatide.	
Date of next meeting: Tuesday 14th March 2023 12:00-14:00 via Teams	