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

Name	Title	Organisation	Apr	May	Jun	Jul	Aug	Sep
Dr Peter Budden (PB) Chair	Medical Prescribing lead	NHS GMIC (Salford)	✓	✓	✓	A	✓	A
Dr Helen Burgess (HB)	GP	NHS GM IC (Manchester)	✓	A	✓	✓	✓	✓
Dr Jonathan Schofield (JS)	Consultant Physician Acute Medicine & Diabetes	Manchester FT	A	✓	A	✓	✓	✓
Suzanne Schneider (SS)	Medicines Information Pharmacist	Bolton FT	✓	✓	A	A	✓	✓
Gary Masterman (GM)	Associate Director of Pharmacy	Wrightington, Wigan and Leigh FT	✓	✓	✓	✓	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				✓
Mina Chowdhury (MC)	Medicines Optimisation Pharmacist	NHS GM IC (Heywood, Middleton & Rochdale)	✓	✓	✓	✓	✓	✓
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	✓	✓	✓	✓	JSe	✓
Matthew Ling (MB)	Deputy Director of Pharmacy	GM Mental Health FT	✓	✓	✓	A	SB	✓
Faduma Abukar (FA)	Head of Medicines Management	NHS GM IC (Stockport)	✓	✓	✓	A	JC	JC
Zoe Trumper (ZT)	Assistant Director of Medicines Management	NHS GM IC (Wigan)	✓	✓	✓	✓	A	✓
Faisal Bokhari (FB)	Deputy Head of Medicines Optimisation	NHS GM IC (Tameside)	A	A	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)	✓	✓	IH	✓	✓	✓
Jole Hannan (JH)	Interface Pharmacist	NHS GM IC (Bolton)	✓	✓	✓	✓	A	✓
Leigh Lord (LL)	Head of Medicines Optimisation and Governance	Manchester FT	✓	A	✓	✓	SBo	✓
Consultant Rheumatologist Audrey Low Ben Parker Charlie Filer Dipak Roy Louise Mercer Meghna Jani Sahena Haque		 SRFT MFT Stockport TGH Stockport SRFT UHSM	A	A	A	A	A	A

Anindita Paul		Bolton						
Dan Newsome (DN)	Principal Pharmacist	RDTC	✓	✓	✓	✓	✓	✓
Nancy Kane (NK)	Senior Medical Information Scientist	RDTC	✓	✓	✓	✓	✓	✓
Andrew Martin (AMart)	Strategic Medicines Optimisation Pharmacist	NHS GM IC	✓	✓	✓	✓	✓	✓
Karina Osowska (KO)	Medicines Optimisation Pharmacist	NHS GM IC	A	✓	✓	✓	✓	✓

1. General Business	
1.1	**Welcome and apologies** Apologies as noted above, the meeting was quorate. Absar Bajwa (Head of Medicines Optimisation – Trafford) and Anna Pracz in attendance for items 4.4 and 4.5 respectively.
1.2	**Declarations of interest** Previously declared where relevant. No further declarations made at the start of the meeting
1.3	**Draft August 2023 CRG Minutes** 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: • Levetiracetam: a North West region position is proposed for this product and will be discussed at the meeting of the NW Medicines Optimisation Group (MOG). If approved the implementation plan will be through the Regional Medical Director to Provider Medical Directors. This action is no longer with CRG and will be closed.
2.0 Matters arising	
2.1	**CRG Consultation July 2023** Only one comment was received and requested further guidance on the use of emollients with antibacterials. CRG will refer this to the antimicrobial steering group for advice **All actions proposed were approved.** **Action**: RDTC to submit all actions to GMMMG for approval.
3.0 Formulary and RAG	
3.1	**Formulary Amendments August 2023** CRG approved the formulary amendments to open for consultation and noted the following: • **NG233: otitis media with effusion in under 12s.** CRG did not think that adding the NICE “do not do” recommendations to the formulary would be helpful but could guide prescribing if added to the GM antimicrobial guidance. **Action: RDTC to open formulary amendments for GMMMG consultation**
3.2	**Update to NHSE Items which should not routinely be prescribed in primary care. Review of GMMMG formulary** A number of updates to the guidance were made as part of a review published in August 2023, This include the removal of tadalafil once daily, an amendment to the wording of herbal products to now include “other

	natural products" and that Omega-3 fatty acid compounds are not recommended with the exception of icosapent ethyl (in line with TA805). CRG agreed to remove tadalafil 5mg from the DNP list and amend the RAG to Green but keep the 2.5mg tablets on due to the price remaining high. The wording amendment to herbal products was approved CRG heard from the lipid specialist on the group that there is a place in therapy for Omacor, where the patient has extreme hyperlipidaemia and is under the care of a specialist, despite the guidance that NHSE have published. To apply a DNP status to this risks prescribing to be transferred to the more costly preparation icosapent ethyl and is unlikely to have the intended impact. Therefore, CRG made the pragmatic decision to maintain the current status and feed into the ongoing work to optimise lipid therapy for CVD reduction being coordinated by the GM SCN. **Decision:** The actions above will be opened for consultation
3.3	**Budget Impact bulletins: Promethazine and Methylphenidate** CRG considered a bulletin for the impact of promethazine prescribing in GM. The methylphenidate bulletin was deferred to October CRG because PB has information pertinent to the conversation and was not present today. Promethazine spend in GM is close to £250k per month on all indications from the 10mg and 25mg tablets alone. These have been subject to both a drug tariff price increase and a concessionary price in the last 12 months. Prescribing rates have also increased by 15% in the same period. Whilst CRG recognised the financial impact, there were concerns that patients for whom the indication is for mental health condition could be adversely impacted and they wanted to get further information from mental health teams before assigning a DNP status. Primary care members recognised the opportunity to review long term prescribing but were cautious of the unintended consequences of preventing prescribing of these products. There is potential for the use of other sedatives which could be more harmful in long term use as alternatives are sought. **Decision**: ML has agreed to provide a summary of the issues at the October meeting
4.0 Pathways and Clinical Guidelines	
4.1	**GM Opioid resource pack** An update to this document has been presented for CRG approval. It has been amended in line with NICE NG 215 - Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults and has had a change to the conversion tables to reflect current best practice guidance. A discussion took place on the query from the author regarding the use of repeat prescriptions for opioids, which whilst not putting on repeat would reflect best practice, this risks the medicine not appearing in their medication history and patient not appearing in practice clinical system searches. It was recommended that the medicine is added to repeats but that a robust process prevents this being issued inappropriately. A potential solution for EMIS systems is to use the variable repeat function. These comments will be communicated to the author. Due to significant changes to the document CRG recommended that a consultation is undertaken and that a clinical check takes place before final approval. **Decision** Request update from author and open for consultation
4.2	**GM long-term azithromycin for chronic respiratory disease guidance** A version of this guidance was presented for approval following consultation. The amendments made were to the monitoring which the respondents believed should be the GP as they believed it was logical for this to

	take place in primary care. Additional information on adverse drug reactions was added. Unfortunately, there were no responses from primary care during the consultation period. CRG discussed the responsibility for initiation and monitoring and thought that this should be the same prescriber. It was also noted that there is significant variation in the way services manage these patients but that the standards set out in the guidance should at least help primary care management of the condition. **Decision** Subject to a minor amendment to wording in section 2.1, the document was approved for submission to GMMMG
4.3	**Omalizumab for Chronic Inducible Urticaria – commissioning statement** The commissioning statement aims to replace IFRs for this medicine for this condition following the ICB decision to move away from IFRs where no clinical exceptionality is demonstrated. For this condition there is a clear cohort and exceptionality therefore cannot be demonstrated. To date all IFRs have been approved and the document aims to standardise entry and exit criteria for the treatment across the ICS and has now undergone consultation. There is no NICE guideline for treatment of urticaria, however both British Association of Dermatologists (BAD) guideline and the international guideline on management of urticaria recommend omalizumab as a 2nd line treatment option in CIndU (if there is poor or no response to the 1st line 2nd generation of H1-antihistamines). The estimated number of patients per year in GM stands at up to 30 and maximum cost is £92,214 (exc VAT) to the GM ICB **Decision** The commissioning statement was approved for submission to GMMMG
4.4	**DOAC switching guide** A document which aims to support clinicians looking to switch patients from a direct oral anticoagulant (DOAC) to edoxaban was presented to CRG for consideration. It aligns with the National Medicines Optimisation Opportunities recommendations for using best value DOACs for treating atrial fibrillation (AF). There are issues with defining best value DOAC whilst questions over generic apixaban price and availability remain however CRG wished concentrate on the guidance rather than choice of DOAC. Even if apixaban is ignored there are potential savings of £1.3m in GM juts by optimising DOAC choice for patients taking dabigatran and rivaroxaban. The document has used a reduced the cut-off for eligibility based on CrCl of 30mL/min rather than the SPC license of 15mL/min. This is due to feedback from secondary care which anecdotally shows an increased risk of bleeding for patients with CrCl <30mL/min. Implementation is available for those who wish to use it, through a third party, the funding for which is being provided by Daiichi Sankyo, and hence the protocol should be robust. CRG noticed some formatting changes which were required in the interactions section, and also highlighted that the patient letters had not been through the ICB comms team for readability checks, this will have to be done at a local level. An issue was picked up that the wording in letters does not match the intent of the protocol, which is to make any changes in conjunction with the patient and is therefore in line with best practice guidance and principles of medicines optimisation. CRG asked that these are amended. An information leaflet for patients was requested to facilitate the discussion between prescriber and patient at the time of making the switch. It was raised that if switches are to go ahead, discussion with community pharmacy at a local level should take place to enable stock to be managed effectively. A shortened governance process was requested by the document authors, however it was not though appropriate to forgo a consultation as there has been little clinical engagement outside the Manchester

	locality and there is no clinical urgency to the work, it has financial implications only. A shortened consultation of 3 weeks, which could be extended, by the professional secretariat in agreement with the Chair if insufficient comments are received. **Decision** Pending the changes to the document and addition of a patient information leaflet, CRG were happy for this to undergo a shortened consultation.
4.5	**GM IBD Pathway** The GM IBD pathway was approved for submission to GMMMG **Decision** Submit to GMMMG for approval
4.6	**GM GLP-1 RA shortage** DN updated the group on the work being done at ICB level to manage the supply shortage of GLP-1 receptor antagonists. A temporary amendment to the formulary for Toujeo has been approved and CRG agreed that the clinical pathways should also be hosted on the GMMMG website. **Decision** Upload guidance to GMMMG website
5.0 Shared care	
No agenda items	
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning August 2023** CRG considered the contents of the document and made the following comments. • Generic ranolazine is now available and should be prescribed by brand name as this is a M/R preparation to ensure ongoing bioavailability • GoResp Digihaler – RDTC are preparing a briefing document on clinical suitability
7.0 AOB • Tirzepatide now has a NICE final draft guidance which recommends its use for type 2 diabetes positioned at the same point in the pathway as the GLP-1 RAs, i.e. after triple therapy with metformin and 2 other agents is ineffective. The TA is due for publication on 11th October and ICB implementation is therefore to be complete by early 2024	
Date of next meeting: Tuesday 10th October 2023 12:00-14:00 via Teams	