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

Name	Title	Organisation	Jun	Jul	Aug	Sep	Oct	Nov
Dr Peter Budden (PB) Chair	Medical Prescribing lead	NHS GMIC (Salford)	✓	A	✓	A	✓	✓
Dr Helen Burgess (HB)	GP	NHS GM IC (Manchester)	✓	✓	✓	✓	✓	
Dr Jonathan Schofield (JS)	Consultant Physician Acute Medicine & Diabetes	Manchester FT	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				✓	✓	✓
Mina Chowdhury (MC)	Medicines Optimisation Pharmacist	NHS GM IC (Heywood, Middleton & Rochdale)	✓	✓	✓	✓	✓	✓
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	✓	✓	JSe	✓	JSe	✓
Matthew Ling (MB)	Deputy Director of Pharmacy	GM Mental Health FT	✓	A	SB	✓	✓	✓ & SB
Faduma Abukar (FA)	Head of Medicines Management	NHS GM IC (Stockport)	✓	A	JC	JC	JC	A
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	✓	✓
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	✓	✓	SBo	✓	✓	✓ & LK
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	✓	✓	✓	✓	✓	✓

1. General Business	
1.1	**Welcome and apologies** Apologies as noted above, the meeting was quorate.
1.2	**Declarations of interest** Previously declared where relevant. No further declarations made at the start of the meeting
1.3	**Draft October 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: • Buvidal: Application still pending. PB to chase • Osteoporosis pathway: work done by the RDTC now complete and will be shared with rheumatology network • Steroid eye drops prescriber information: The RAG change request associated with this was approved by GMMMG on 9th November. This document is now required before the change can be made to formulary and RAG list • ETP from secondary care sites: raised at GMMMG on 9th November, GMMMG chair has taken an action to discuss the delay in implementation – item now closed.
2.0 Matters arising	
2.1	**CRG Consultation September 2023** One comment was received through the consultation, regarding the tadalafil daily 5mg tablets. This agreed with the action but was concerned that the removal could signal a relaxation in its use for men with LUTS. CRG were reminded that the SLS criteria still exist for PDE-5 inhibitors with the exception of generic sildenafil, this would therefore not be permitted. **All actions proposed were approved.** **Action**: RDTC to submit actions to GMMMG for approval.
3.0 Formulary and RAG	
3.1	**Formulary Amendments October 2023** CRG approved the formulary amendments to open for consultation and noted the following: • **TA919: Rimegepant for treating migraine.** The NICE cost estimate of less than £8800 per 100,000 population looks low for a medicine which appears so early in the treatment pathway and is significantly more expensive than the triptans. It was clear from the start of the discussion that this medicine is not suitable for specialist initiation, as unlike the pending formulary recommendation in response to NICE TA906 for preventative treatment of episodic migraine, the acute migraine patients are not seen by specialist services, who would not have the capacity to take on this activity. By positioning as Green it is placed before other treatments which require specialist input with the

	unintended consequence of creating a pathway whereby medicines available in primary care will inevitably be tried before (or alongside) a referral to the specialist. Use of advice and guidance would help in advance of a clinical pathway to identify the cohort of patients for whom this is suitable and those which should be referred. Work is now underway to update the GM headache pathway which will support primary care prescribing, until this is available a status of Green specialist advice is proposed. • **TA922: Daridorexant for treating long-term insomnia.** CRG noted that CBTi is not available in all areas and therefore this medicine becomes a first-line treatment for insomnia. It is likely to have a significant impact up to £350k in year 1 and £2m by year 5 which could be mitigated with further commissioning on non-pharmacological treatments. CRG also highlighted that this is more expensive than alternative products, there is no proposed deprescribing strategy described by NICE despite the recommendation that treatment does not exceed 12 months, training must be provided to primary care prescribers before using the medicine and patients with a history of mental health disorders were excluded from clinical trials. The agreement was that daridorexant should be available as a Green specialist advice, and that it should not be prescribed to patients with a history of mental health conditions, and should not be prescribed until the prescriber has received training to do so. Mental health representatives confirmed that the exclusion of this group of patients was not disproportionate. They also wished to raise the issue of commissioning of non-pharmacological alternatives including Sleepio which was recommended for commissioning by this group in 2022. • **TA924: Tirzepatide for treating type 2 diabetes.** There is as yet no stock available of this medicine in the UK, despite it being licensed as a vial and pre-filled syringe. A further product license is pending for a pre-filled pen. CRG heard that it is positioned in the same place as GLP-1 inhibitors within the T2DM treatment pathway but has yet to gain any evidence for CVD benefits unlike the majority of GLP-1s. Historically choice of GLP-1 has been based on the availability and quality of CVD outcome data, but with the stock issues affecting GLP-1 products likely to continue into mid 2024, tirzepatide is likely to be selected because of its availability rather than proven benefits compared to established GLP-1 medicines. Clinical input suggests that dose escalation is likely to 10mg or 15mg which significantly impacts the cost to the GM system as the cost of the product is dose dependant and ranges from £1196 to £1495 per year per person. A position and place in therapy will be sought from the GM Diabetes Strategy Board to aid with formulary placing, however the medicines will be assigned a Green status for consultation. **<u>Action</u>: RDTC to open formulary amendments for GMMMG consultation**
3.2	**Mental health services impact of DNP position for promethazine 10mg and 25mg tablets** ML presented a summary of the mental health position which focussed on hydroxyzine as an unsuitable alternative due to its potential for QT interval prolongation and unclear place in therapy. Promethazine is an accepted oral sedative within mental health services and is recognised by Joint BAP NAPICU evidence-based consensus guidelines but may find its way into primary care on discharge. The GM mental health pharmacy services have agreed to propose that all transfer of promethazine into primary care will cease and this will be discussed at ratified at internal medicines management group meetings in November. This is supported by both trusts. Following this there is support for deprescribing in primary care and SB committed to work with GMMMG to provide this, where deprescribing is not appropriate then a switch to an alternative product is warranted. **<u>Decision:</u>** SB to report back to CRG when internal discussions have taken place to enable this work to be taken forward
3.3	**Carbimazole 10mg and 15mg tablets RAG review** This request sought to add carbimazole 10mg and 15mg tablets to the DNP list. These are not listed on the GM formulary but during the 2022-23 financial year represent £156k of prescribing costs. It is estimated that £149k of this could be avoided with a full switch to the 5mg tablets.

	CRG did not think there was any clinical risk associated with this proposal to move to a more cost-effective preparation. The DNP criterion 2 appears the most appropriate: Criterion 2: Products which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation. **Decision:** The proposal to add carbimazole 10mg and 15mg tablets to the DNP list was accepted. Open for GM-wide consultation
3.4	**Oral mucolytics – acetylcysteine and carbocisteine** CRG were presented with a proposal to amend the formulary to place acetylcysteine as the first choice mucolytic in COPD. It is more cost-effective than carbocisteine 375mg capsules when prescribed as the 600mg effervescent tablets, is taken once daily rather than 2-3 times daily and doesn't need to have the dose reduced when the patients condition improves. Acetylcysteine is not suitable for patients for whom sodium content is a concern, in which case carbocisteine would be appropriate. A RAG status of Green will also be applied to each of these products. **Decision:** Open for GM-wide consultation
4.0 Pathways and Clinical Guidelines	
4.1	**MHRA advice – Isotretinoin** LL asked CRG to consider an ICS-wide response to the updated requirements on prescribing isotretinoin, published by the MHRA on 31st October 2023. Initiation of the medicines now requires 2 prescribers to agree on the treatment and there are new counselling requirements. Secondary care representatives stated that the logical implementation would be to use a MDT group to agree to the prescribing, however this may not be available to all providers. In the absence of a specific ICB committee to report to, it was agreed that trust MSOs should collate the information and co-ordinate with GMMMG for assurance that the alert had been actioned. CRG did not believe that this was within the terms of reference. PM requested material for community pharmacy on the new counselling requirements. Despite this being a RED drug in GM, some prescribing is on FP10HP as well as some being issued by primary care prescribers, however the expectation is that primary care prescribing will cease. **Recommendation** It seems sensible to tackle this ICS-wide. LL will work with PM to develop some counselling materials for community pharmacy and the trust MSOs should feed assurance to GMMMG. DN to work with LL to facilitate this.
5.0 Shared care	
5.1	**Update on shared care** DN provided an update to state that the RDTC were preparing the national SCPs for approval using ICB governance processes. The remaining GM SCPs will be updated locally
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning October 2023** CRG considered the contents of the document and made the following comments. • None
7.0 AOB	

- None raised

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