Minutes of the GMMMG Clinical Reference Group Meeting
Tuesday February 13th, 2024, 12:00-14:00
via MS Teams

Name	Title	Organisation	Sep	Oct	Nov	Dec	Jan	Feb
Dr Peter Budden (PB) Chair	Medical Prescribing lead	NHS GMIC (Salford)	A	✓	✓	✓	✓	✓
Dr Jonathan Schofield (JS)	Consultant Physician Acute Medicine & Diabetes	Manchester FT	✓	✓	✓	A	A	✓
Suzanne Schneider (SS)	Medicines Information Pharmacist	Bolton FT	✓	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓	✓
Mina Chowdhury (MC)	Medicines Optimisation Pharmacist	NHS GM IC (Heywood, Middleton & Rochdale)	✓	✓	✓	✓	A	A
Lucy Tetler (LT)	Medicines Optimisation Pharmacist	NHS GM IC (Bury)	✓	JSe	✓	✓	✓	✓
Matthew Ling (MB)	Deputy Director of Pharmacy	GM Mental Health FT	✓	✓	✓ & SB	✓	✓	A
Faduma Abukar (FA)	Head of Medicines Management	NHS GM IC (Stockport)	JC	JC	A	A	A	A
Zoe Trumper (ZT)	Assistant Director of Medicines Management	NHS GM IC (Wigan)	✓	✓	✓	✓	✓	✓
Sarah Hafeez (SH)	Advanced Medicines Optimisation Pharmacist	NHS GM IC (Tameside)	FB	FB	FB	FB	✓	✓
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	✓
Jole Hannan (JH)	Interface Pharmacist	NHS GM IC (Bolton)	✓	✓	✓	✓	✓	✓
Leigh Lord (LL)	Head of Medicines Optimisation and Governance	Manchester FT	✓	✓	✓ & LK	✓	✓	✓
Consultant Rheumatologist Audrey Low Charlie Filer Dipak Roy Louise Mercer Sahena Haque Anindita Paul		 SRFT Stockport TGH Stockport UHSM Bolton	A	A	A	AL	A	A
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. Dr Sanjay Wahie and Dr Ann Harrison were in attendance to provide additional GP representation
1.2	**Declarations of interest** Previously declared where relevant. No further declarations made at the start of the meeting
1.3	**Draft January 2024 CRG Minutes** The minutes were approved for publication to the GMMMG website with a minor amendment to the title
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: • Due to inactivity the actinic keratosis pathway will be removed from the action log and those who signalled their intent to be involved will be informed. This does not prevent a further request for tirbanibulin to be added to formulary at a later date, should a pathway be created. • Buvidal: Application still pending, LL and ZT have agreed to try again for an application • Tirzepatide: positioning of this treatment within the T2DM pathway has been requested from the GM diabetes strategy board. Discussions now underway with diabetes strategy board however this decision has been passed to GMMMG so is no longer CRG's action. Closed • Promethazine tablets: Draft guidance has been shared with PB which will be amended and is scheduled for discussion at CRG in March.
2.0 Matters arising	
2.1	**CRG Consultation November 2023** The comments received through the consultation were discussed, including following items: **Cytisine 1.5mg tablets:** The large number of comments were supportive of this medicine being added to the formulary. CRG understand that PGDs are in development to ensure supply via commissioned services does not require GP prescription, this is expected to be ready around the same time as the medicine is added to formulary. **TA929: Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction.** A request to consider a Green status was received through the consultation, however it was the opinion of the group that the experience and competence of GPs in this clinical area varies. Having a requirement to use advice and guidance to ensure that other pharmacological options have been titrated as far as possible, in line with current best practice, was agreed by CRG. **All other actions proposed were approved.** **<u>Action</u>**: RDTC to submit actions to GMMMG for approval and/or discussion.
3.0 Formulary and RAG	
3.1	**Formulary Amendments January 2024** CRG approved the formulary amendments to open for consultation and noted the following: • **Diclofenac as third-line NSAID:** This should remain as Green but be clearly positioned as a 3rd line choice if ibuprofen and naproxen are not suitable, with links to the relevant MHRA warnings

	• **<u>Action</u>: RDTC to open formulary amendments for GMMMG consultation**
3.2	**Formulary request – riluzole orodispersible tablets** A request to add the orodispersible form of riluzole 50mg tablets to the formulary was received as part of the work to update the shared care protocol for this medicine. CRG heard that there is no difference in the safety and efficacy profile of the orodispersible tablet versus the standard 50mg tablets, however there is an additional risk of mild transient oral hypoesthesia with the proposed product. Due to a sudden increase in price of riluzole 50mg tablets, at least in part, caused by the withdrawal of one or more manufacturers from the UK market, resulting in a shortage of the standard 50mg tablets, the cost of the orodispersible is lower (£168) than standard tablets (£300.23) for 56 tablets and so represents an opportunity to mitigate the prices rises. A request to expedite this addition was received. Unfortunately, there is no mechanism to do this at present but CRG suggested that a request from specialist to GP to use the cost-effective alternative is unlikely to be refused provided the rationale is clearly explained. **<u>Decision:</u>** Open decision to add to formulary to consultation
3.3	**RAG change request – doxazosin 8mg immediate release tablets** This item was not discussed due to time constraints **Decision:** Item deferred to March meeting
3.4	**Alternatives to omeprazole oral suspension for children scoping document** This item was not discussed due to time constraints **Decision:** Item deferred to March meeting
4.0 Pathways and Clinical Guidelines	
4.1	**Steroid eye drops – discussion with specialist service** Professor Fiona Carley, Consultant Ophthalmic Surgeon, MREH attended CRG to discuss the monitoring requirements of topical steroid preparations for use in primary care. CRG have been seeking guidance from ophthalmology services regarding the long-term use of steroid eye drops when being prescribed in primary care, this is in response to a request to amend the RAG status of these preparations from RED to Green (specialist initiation). A guidance document first considered by CRG in August 2023 recommended 3-month intervals which Prof Carley stated would not be clinically appropriate nor manageable from a service provision perspective. Patients seen in MREH uveitis and corneal service are reviewed from between every 6 weeks to every 12 months depending on their indication and choice of treatment prescribed. CRG heard that the service is keen to ensure the patients are adequately followed-up by the specialist and are happy to take responsibility for the communication of review periods to the patient's GP via clinical letter. The ability of the practice to detect when this review period has passed and prevent inappropriate prescribing of steroid eye drops depends on the robustness of the practice's system in place to manage repeat prescribing, but CRG acknowledged the risk cannot be totally removed. A proposal that standard intervals of review are 3, 6 or 12 months, and that this will be clearly set out to the patient's GP practice in communication from the specialist was accepted by CRG. **Recommendation:** The authors of the guidance leaflet will work with Prof Carley to action the changes discussed today and those comments received through the consultation held from August 2023, and return the document to CRG for approval

4.2	**Statins for primary prevention in HIV – position statement** CRG were joined by Dr Clare VanHalsema, Consultant in infectious diseases at MFT to explain the rationale for this recommendation. It is proposed that the GM ICB publish a statement to recommend statin prescribing for all patients living with HIV over the age of 40 years. This is because the evidence base shows the cardiovascular risk for this group is up to double that of the general population and is supported by the British HIV association (BHIVA), as well as being in line with NICE NG238. The evidence is based on the use of pitavastatin which is not available in the UK, however many years of statin prescribing shows that there is a class effect for CVD risk reduction based on the degree of lipid lowering effect. There will be no case-finding for primary care, the recommendation to initiate statin therapy will come from the HIV service with a named medicine and starting dose included. Because HIV medicines often have significant interactions with other medicines it is recommended that primary care consult the University of Liverpool HIV drug interactions checker before changing the patient's therapy. CRG pointed out that this is not a resource that primary care will be familiar with and that not all practices will ensure that hospital-prescribed medicines are included on the patient's clinical record. Therefore, there is a risk that potentially clinically significant interactions are missed and so CRG asked for the specialist to make clear recommendations on the medicine, dose and safe range that can be prescribed with the patients antiretroviral therapy at the point of making the recommendation to the GP. Some patients living with HIV (less than 5%) do not give consent to information sharing with their GP on their HIV status, therefore it will not be possible to request primary care prescribe statins for this group and a process is underway to seek a mechanism for long term prescribing from the HIV service. The cost impact on the GM ICB is expected to be £70k per year if all patients living with HIV over 40 are treated with atorvastatin 20mg daily. **Decision** CRG accepted the commissioning statement and the proposal but asked for some minor amendments to be included in the document before opening a consultation.
4.3	**DOAC switch guide** An updated version of the document that was approved by CRG and opened for consultation in 2023 was considered by CRG. This now matches the new NHSE commissioning recommendations for DOAC use for non-valvular atrial fibrillation (NVAF) which position generic apixaban as the first line option and edoxaban as 2nd choice based on cost-effectiveness. It also requested that the GM ICB adopt the hierarchy of rivaroxaban 3rd line, dabigatran 4th and branded apixaban (Eliquis®) 5th, to be reflected on the GMMMG formulary. **Decision** Approved for consultation
4.4	**ADHD medicines shortage – update to ICB comms** CRG approved the update to this piece of guidance and noted that guanfacine is now back in stock so the document is already out of date. However, it was accepted that this type of publication will often contain out of date information due to the governance process that supports it but that this does not detract from the principles contained within it. **Decision** The technical update was approved for publication
4.5	**Gabapentinoids resource pack** This document was removed form the GMMMG website after it reached its expiry date as part of routine housekeeping and permission is sought from CRG to republish with a suggested 2-year expiry date. A check of the content has been undertaken by the NHS GM MO team which has determined the content is clinically accurate. **Decision**

	CRG approved the document to be republished with a 2-year expiry
5.0 Shared care	
5.1	**Riluzole shared care protocol** CRG received this shared care protocol following minor updates being made to badge for the GM ICS and after confirmation was received from the MND team that they were happy with the content **Decision** Approved for ratification by GMMMG
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning January 2024** CRG considered the contents of the document and made the following comments. • A new formulation of vitamin D is available as Colextra-D3. It was noted that an update to the GM vitamin D guidance remains outstanding • Generics of dabigatran and rivaroxaban are receiving licenses but the latter is unlikely to become available due to ongoing disputes about patent protection • A new drug evaluation of fezolinetant for vasomotor symptoms associated with the menopause is being conducted by RDTC. CRG heard that the product is unlikely to be available for NHS prescribing until a NICE TA is completed which is due to begin in July 2024.
7.0 AOB • None raised	
Date of next meeting: Tuesday 12th March 2024 12:00-14:00 via Teams	