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

Name	Title	Organisation	Oct	Nov	Dec	Jan	Feb	Mar
Dr Peter Budden (PB) Chair	Medical Prescribing lead	NHS GMIC (Salford)	✓	✓	✓	✓	✓	✓
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	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	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	A	A	A	A	A
Zoe Trumper (ZT)	Assistant Director of Medicines Management	NHS GM IC (Wigan)	✓	✓	✓	✓	✓	A
Sarah Hafeez (SH)	Advanced Medicines Optimisation Pharmacist	NHS GM IC (Tameside)	FB	FB	FB	✓	✓	✓
Jennifer Bartlett (JB)	Team Leader Neighbourhood Integrated Practice Pharmacists	Salford Royal FT	✓	✓	✓	✓	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	AL	A	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.
1.2	**Declarations of interest** Previously declared where relevant. No further declarations made at the start of the meeting
1.3	**Draft February 2024 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: a communication was received just prior to the meeting that a GN-wide application is being prepared • Promethazine tablets: The anticipated draft guidance is not ready and is still under discussion by GMMH Medical Leadership Committee and is being looked at in conjunction with promazine.
2.0 Matters arising	
2.1	**CRG Consultation January 2024** The comments received through the consultation were discussed, including following items: • **Melatonin liquid choices:** Feedback agrees with the proposal but raises the same points that CRG did in January regarding ensuring that liquids are reserved for only where absolutely necessary and concerns around the correct product selection at the points of prescribing and dispensing. CRG agreed with the issues raised and will request assurance from MH pharmacy leads through GMMMG and CEGC that MH teams will follow the approved formulary choices and adhere to the shared care protocol. **All other actions proposed were approved.** **Action**: RDTC to submit actions to GMMMG for approval and/or discussion.
3.0 Formulary and RAG	
3.1	**Formulary Amendments February 2024** CRG approved the formulary amendments to open for consultation and noted the following: • **Codeine linctus change to POM:** A query was raised that there is no date from which the change is effective. Further communication from the RPS and information from the product SmPC shows that this change is already in place but stock may remain which is labelled as “P” with the recommendation is to treat as a POM. • **Salbutamol nebules shortage:** CRG discussed the need for a GM response to this issue, however it was agreed that comms to primary care would not likely contain any further info than that in the Medicine Supply Notification (MSN) and other information sources already available.
3.2	**Formulary change request – opicapone 50mg tablets** A request to change the RAG status of opicapone was received. It is currently on the formulary with a Grey/Green (specialist initiation) medicine status for use only where entacapone (either alone or in

	combination) is considered not suitable, however the request was to amend to Green (specialist initiation) as equal first-line COM-T inhibitor alongside entacapone. CRG heard the decision to assign this status was based on a NICE evidence summary from 2017 and a RDTC new drug evaluation from the same year. The evidence shows non-inferiority vs entacapone but any benefit over existing therapy was not adequately demonstrated and was at a significantly higher cost. The price of opicapone has now decreased by about 30% and is similarly priced to entacapone for a year's treatment. There may also be benefits from its once daily administration, but CRG questioned this as patients would usually also be taking multiple daily doses of levodopa anyway. The rationale for the request was that under current formulary positioning patients should be offered and have failed on entacapone treatment prior to opicapone, however this is not consistent with the current formulary status and prescribing data shows that 47% of patient prescribed a COM-T inhibitor in GM in the last 12 months received opicapone. CRG did not accept that the case for changing the formulary had been adequately made, nor that the current formulary status was no longer appropriate or too restrictive. **Decision:** Application for amendment of RAG status was not approved. This can be reconsidered if further information is provided to demonstrate the need to change the status
3.3	**RAG change request – doxazosin 8mg immediate release tablets** CRG received a proposal to add doxazosin 8mg immediate release tablets to the DNP based on their price. 28 x 8mg IR is £9.49 vs 56 x 4mg IR is £1.68 (Mar DT). GM spends £187k per year (Nov 22 – Oct 23) on doxazosin 8mg immediate release which could provide a saving of £152k per year if all were switched to 2x4mg IR. **Decision:** CRG agreed with the proposal to add doxazosin 8mg immediate release tablets to the DNP list as 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.) and will open for GM-wide consultation.
3.4	**Alternatives to omeprazole oral suspension for children scoping document** CRG heard a proposal to develop guidance on the use of alternatives to omeprazole oral suspension for children and recognised the cost impact that this area of prescribing was having (£1.6m in 12 months to Sep 23) but were reminded of an incident in GM some years ago where a child choked on a MUPs tablet. The main areas that CRG agreed guidance would be helpful is for under 1 years of age and where very small doses are required. They expressed caution with dispersing tablets in drawing up as these manipulations are not usually licensed and can lead to dosing errors, however PPIs are considered relatively safe medicines. The guidance produced would have to balance off-label use against the availability of licensed preparations as it was suggested much of the prescribing of omeprazole suspension is in order to use a licensed product. Comments on inclusion of the potential for dose banding and preventing interactions with oral feeds will be communicated to the authors. **Decision:** CRG would like to see this guidance taken forward
3.5	**RAG change request – atropine eye drops for hypersalivation** These eye drops are sometimes used off-label to treat hypersalivation in line with the GMMMG hypersalivation pathway, however clinicians have asked that the RAG status is amended from Green (specialist initiation) to Green (specialist advice) to support initiation in the community by specialist teams. CRG agreed with the rationale for the change and highlighted again that it is imperative that secondary care prescribers are provided with an appropriate option to issue prescriptions, e.g. FP10HP pad as well as their own prescription code and cost-centre and the ability to prescribe electronically. **Decision** CRG agreed with the request and will open for consultation

4.0 Pathways and Clinical Guidelines	
4.1	**GM asthma guidance** The planned update of this guidance has been brought forward due to the availability of Symbicort Turbohaler receiving a marketing authorisation for anti-inflammatory reliever (AIR) therapy and to align with the Global Initiative for Asthma (GINA) recommendations. It is understood that NICE guidance is in the process of being updated. The guideline has been developed and approved by the GM Asthma working group and is submitted for approval to open for consultation across GM. It translates the recommendations made from GINA, NICE and BTS into product choices based on device type and size of carbon footprint. The main difference with previous versions is the emphasis on AIR and MART therapy, removing the preference for separate reliever and preventer inhaler devices due to evidence of fewer exacerbations when compared to using a SABA inhaler. The guidance is anticipated to be cost saving both in terms of medicines spend and a reduction in the number of exacerbations, hospital admissions and the ICS carbon footprint could save up to £78k per year for GM **Recommendation:** CRG approved to open for consultation
4.2	**GM tobacco dependence pathway** This update to an existing pathway was received by CRG to include cytisine which is in the process of being added to the GMMMG formulary following approval by this group. The update also includes an increase in NRT dosing with patches to align with current recommendations from NCSCT when >40 cigarettes per day are used and wording to match a recent clinical statement from BTS. CRG asked for information on the development of PGDs and requested that these are designed for use by the whole ICS and not just a single service. It is understood that this request has been made already. Primary care representatives asked about the provision for recharging public health budgets for costs incurred to the ICB for the supply of cytisine. This question will be asked through GMMMG and CEGC when the document is submitted for approval. **Decision** Approved to open for consultation
4.3	**Updated levonorgestrel-containing IUS comparison table** This item was deferred to April meeting
5.0 Shared care	
5.1	**Paliperidone LAI shared care protocol and formulary application for 6-month injection** This is an update to an existing SCP which now includes 3-monthly injection, which is already included in the GMMMG formulary, and the 6-monthly injection which is an addition. CRG heard that patients would be stabilised on monthly dosing before consideration for a switch to a longer-acting preparation. There is no difference in the annual cost for the 3 or 6 monthly preparation and both offer advantages nor in the safety or efficacy profiles. However, there are extra considerations for those who may become pregnant or breastfeed because the blood plasma levels of paliperidone may persist for up to 4 years after dosing on the 6-month preparation A number of other sections have been updated in conjunction with pharmacy at Pennine Care NHS FT. CRG recognised that the model of care used for patients receiving long-acting antipsychotic injections varies depending on locality and service, and that those patients seen by GMMH receive their LAIs from CPNs rather than their GP, and so shared care does not apply.

	Pending some minor amendments to wording in the baseline monitoring and pregnancy and breastfeeding sections, CRG were happy with the document. **Decision** Approved for consultation on the document and 6-monthly preparation.
5.2	**Amiodarone and dronedarone shared care protocols** Following discussion at December 2023 CRG meeting, these two shared care protocols have been discussed with cardiology services at MFT and NCA and have been adapted for use by the ICS. A further discussion took place about the RAG status of these medicines; however the problems being experienced by some services in transferring prescribing to primary care necessitates the use of a SCP to facilitate this transition. The RAG status then aligns with NHSE guidance on medicines which should not be routinely prescribed in primary care, which the ICB has formally adopted. Due to a previous consultation and the need to implement a solution quickly to facilitate transfer of prescribing and ensure patients get the most appropriate treatment, a further consultation was deemed unnecessary. **Decision** Approved for submission to GMMMG for ratification
6.0 Work plan and horizon scanning	
6.1	**Monthly horizon scanning February 2024** CRG considered the contents of the document and made the following comments. • Levomepromazine 6.25mg tablets. These provide a licensed option to off-label use, mostly in palliative care, but at significant cost. The RDTC are developing a formulary assessment tool to return this product to April CRG for further discussion
7.0 AOB • Dr Ann Harrison (Clinical Lead for MO Trafford locality) will join CRG to provide additional GP input from the April meeting	
Date of next meeting: Tuesday 9th April 2024 12:00-14:00 via Teams	