# Minutes of the GMMMG Clinical Reference Group Meeting
# Tuesday April 9th, 2024, 12:00-14:00
# via MS Teams

| Name | Title | Organisation | Nov | Dec | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|---|---|---|
| Dr Peter Budden (PB) Chair | Medical Prescribing lead | NHS GMIC (Salford) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Ann Harrison | Deputy AMD<br>Clinical lead for Primary Care, Medicines Optimisation and Cancer | NHS GMIC (Trafford) | | | | | | ✓ |
| Dr Jonathan Schofield (JS) | Consultant Physician Acute Medicine & Diabetes | Manchester FT | ✓ | A | 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 | 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 | A |
| Lucy Tetler (LT) | Medicines Optimisation Pharmacist | NHS GM IC (Bury) | ✓ | ✓ | ✓ | ✓ | ✓ | A |
| Matthew Ling (MB) | Deputy Director of Pharmacy | GM Mental Health FT | ✓ & SB | ✓ | ✓ | A | ✓ | SB |
| Faduma Abukar (FA) | Head of Medicines Management | NHS GM IC (Stockport) | A | 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 | ✓ | ✓ | ✓ | ✓ |
| 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 | ✓ | ✓ | ✓ | ✓ | A (LK) |
| Consultant Rheumatologist<br>Audrey Low<br>Charlie Filer<br>Dipak Roy<br>Louise Mercer<br>Sahena Haque | | SRFT<br>Stockport TGH<br>Stockport UHSM | A | AL | A | A | A | A |

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| 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 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

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| **1. General Business** | |
| **1.1** | **Welcome and apologies**<br>Apologies as noted above, CRG welcomed Dr Ann Harrison who will join CRG to provide additional GP input to the group. |
| **1.2** | **Declarations of interest**<br>Previously declared where relevant. No further declarations made at the start of the meeting |
| **1.3** | **Draft March 2024 CRG Minutes**<br>The minutes were approved for publication to the GMMMG website. It was noted that the levomepromazine formulary assessment tool will now be tabled at the May meeting of CRG. |
| **1.4** | **Action log review**<br>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:<br>• Promethazine tablets: The work to obtain mental health input to this decision is now inextricably linked to the use of promazine tablets after being presented to GMMMH consultants for a consensus agreement. The feedback from this process so far is that specialists want to keep the option of prescribing either promazine or promethazine, the indication for their use and rationale or evidence base for this recommendation is not clear. Therefore, the cessation of promazine could lead to an increase in promethazine prescribing and vice versa. It was pointed out that the initial request to CRG was to deprescribe promethazine 10mg and 25mg tablets due to excessive price increases and that other options do exist. If a consensus from mental health services is not reached by June this issue will be escalated through ICB governance to reach a resolution as the failure to make progress has a significant cost in excess spend on these medicines. |
| **2.0 Matters arising** | |
| 2.1 | **CRG Consultation January 2024**<br>The comments received through the consultation were noted and all items approved.<br>**Action**: RDTC to submit actions to GMMMG for approval and/or discussion. |
| **3.0 Formulary and RAG** | |
| **3.1** | **Formulary Amendments March 2024**<br>CRG approved the formulary amendments to open for consultation and noted the following:<br>• **TA958; ritlecitinib for alopecia:** CRG queried what services are in place to provide this treatment. AMarr confirmed dermatology at SRFT have identified an eligible cohort and are asking to use the medicine through an established alopecia clinic. It was mentioned that a working group in GM is looking at dermatology service provision across the ICS as there is a possibility that further capacity may need to be commissioned in future. Interested parties have been asked to feed into the CRG consultation when it opens to confirm patient numbers and anticipated costs. |

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| | • **NG239: Vitamin b12 deficiency guidance**: CRG agreed the need to add an oral preparation to formulary and a piece of work will be undertaken by RDTC to identify the most cost-effective products available.<br>• **Doxylamine / pyridoxine (Xonvea®) for management of nausea and vomiting in pregnancy.** A request was made for a GM position on the use of this agent despite the RCOG guidance. Many prescribers will understandably wish to use a licensed medicine ahead of an unlicensed preparation and since Xonvea is the only licensed product in this therapeutic area, the additional cost over more established treatments could be significant. CRG agreed that cyclizine and prochlorperazine should remain first line with Xonvea removed from the grey list and positioned as a first line option in line with RCOG recommendations. Metoclopramide should be changed to an alternative second-line option.<br>• **Withdrawal of Innolet devices:** CRG questioned if patients using Innolet insulin delivery devices, (up to 200 patients in GM) would have sufficient options on the formulary to change to as these are designed for use by those who are visually impaired. It was stated that the only option for these groups may now be third-party administration but a review with their practice diabetes service was the first step. Comms to the system have been agreed to come from the GM diabetes board.<br><br>**Decision:**<br>Open for GM wide consultation |
| **3.2** | **Buvidal formulary request**<br>An application to add buprenorphine long-acting subcutaneous injection (Buvidal) to the formulary was received from the strategic lead for substance misuse services in GM. This originated from a request for clarification of its use and formulary position from acute trusts who occasionally see patients attend their services who are prescribed the medicine. It is understood that there are around 670 patients currently prescribed the treatment in GM.<br>CRG accepted the application as an alternative to methadone and oral buprenorphine when these were not suitable and further discussed the RAG status that should be applied. Methadone and oral buprenorphine have a status of "*RAG status depends on local commissioning arrangements for substance misuse or if GP with specialist interest*" to ensure that GM's wide range of commissioned services are not inappropriately restricted by the formulary RAG. CRG agreed to apply the same status to Buvidal.<br>The funding for prescribing of substance misuse treatments is currently via national drug strategy but this is only guaranteed until end of 24-25 financial year. Therefore this will not affect the ICB's medicines spend in any meaningful way unless there is a change of commissioning responsibility, but as far as CRG were aware there are no plans to make any changes to these arrangements.<br><br>**Decision:**<br>Application approved for consultation as an alternative to methadone and oral buprenorphine with a RAG status of: "*RAG status depends on local commissioning arrangements for substance misuse or if GP with specialist interest*" |
| **4.0 Pathways and Clinical Guidelines** | |
| **4.1** | **Steroid eye drops for ophthalmic indications – primary care info leaflet**<br>This document returned for approval to be ratified by GMMMG after discussion with the specialist at the February 2024 meeting. A number of amendments have been made and CRG had the following requests for clarification:<br>• The leaflet was intended for adults but a reference to children has been inserted, could this be removed?<br>• For ease of reading could the information on the stabilisation of dose by the specialist service be moved to the top of the document. |

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| | • CRG didn't recognise the "urgent alert" system and asked if this was a MFT specific system and if it is applicable to all areas of GM<br>• To make clear that the licensed indications are for short-term use only and the majority (if not all) of use here was off-label<br>• Clarification on the role of community ophthalmology services which will be sought through LOC contacts if required.<br>DN will communicate the comments with authors and if all can be addressed then this document can be approved for submission to GMMMG<br>**Recommendation:**<br>Amend and seek permission from authors to progress |
| **4.2** | **Updated levonorgestrel-containing IUS comparison table**<br>An update to the existing levonorgestrel-containing intrauterine systems comparison table was submitted for approval. This has been updated in conjunction with Dr Navani to reflect the changes in licensing to existing products and the addition of Benilexa as approved at the March meeting.<br>**Decision**<br>Approved as technical update for ratification by GMMMG |
| **5.0 Shared care** | |
| **5.1** | **Hydroxycarbamide SCP**<br>KO has been liaising with haematology services to finalise the GM version of the national shared care protocols for hydroxycarbamide, based on the update done by RDTC. Confirmation from the local services that the document represents current practice was received with the exception of the indication of CML, which has been removed.<br>A query was raised over the recommendations for washout before pregnancy for both male and female patients. The RDTC documentation stated effective contraception should be used for 3-6 months for female and 3 months for male patients after cessation of hydroxycarbamide. This is based on a paucity of evidence which informs the product SPCs and on advice sought from the UK Teratology Information Service. During the meeting CRG agreed with the recommendations made by specialist services which was for the shortest washout period for each. However after the meeting, further correspondence from haematology has shown that 3-6 months for female and 3 months for male patients is the most appropriate recommendation for the GM system.<br>A second query about the monitoring of reticulocyte count was raised by GP representatives. The document states that this may be as frequent as every two weeks for those on maximum dose. CRG understood that use of this high dose is very uncommon but would still be appropriate for the document to permit transfer of these patients to primary care because it remains an option for the GP to decline shared care if they were unable to fulfil the very frequent monitoring requirements. Clarification is being sought from specialist services on how many patients GM can expect on maximum dose hydroxycarbamide.<br>It is understood that a request for the addition of liquid and tablet preparations has been made to KO. These are not on the formulary because they are significantly more expensive than capsules. Without a formulary application to understand the patient cohort and why these are required they cannot be includes. A formulary application has therefore been requested.<br>**Decision**<br>The document has already received a national and GM-wide consultation so a further period was deemed unnecessary. It was therefore approved for ratification by GMMMG. |
| **6.0 Work plan and horizon scanning** | |
| **6.1** | **Monthly horizon scanning March 2024**<br>CRG considered the contents of the document and made the following comments. |

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| | • A number of rivaroxaban 2.5mg tablets are becoming available as generic products. This is not the dose used for stroke prevention in AF but for prophylaxis in CAD/PAD and post-ACS.<br>• Linked to the above, CRG heard that not all generic apixaban packaging contains the DOAC alert card which is important information for the patient and should be provided on initiation. CRG asked that this is included in the DOAC strategy document due to come back to CRG in May and that prescribers and dispensers are reminded of the need to provide this information. All products have an alert card which is available alongside their SPC at the electronic medicines compendium. |

**7.0 AOB**

- No items were raised

**Date of next meeting: Tuesday 14th May 2024 12:00-14:00 via Teams**