Integrated Medicines Optimisation Group (IMOG)
Wednesday 10th January 2024 - 2.00pm-4.00pm
CONFIRMED MINUTES

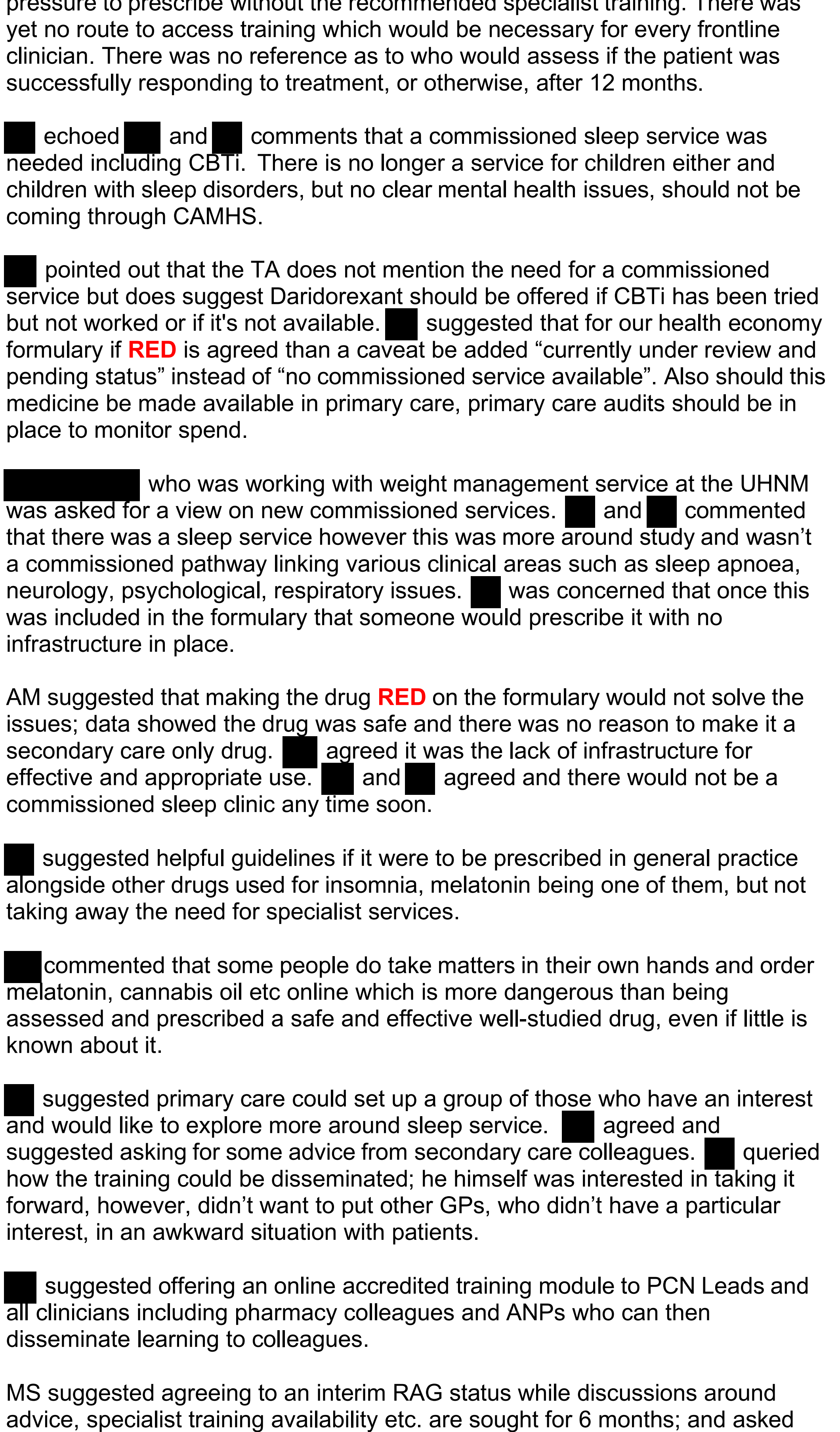
Members:		**initials**	**Quoracy**	**06.09.2023**	**04.10.2023**	**01.11.2023**	**06.12.2023**	**10.01.2024**
Chair:	Mark Stone	MS	The meeting will be quorate if there at least two GP representatives, two lead provider representatives (UHNM, MPFT and NSCHT) and one ICB pharmacist present.	Y	Y	Y	Y	Y
University Hospitals of North Midlands (UHNM)	[redacted]	[redacted]		Y	A	Y	Y	Y
	[redacted]	[redacted]		Y	Y	Y	Y	A
Midlands Partnership NHS Foundation Trust* (MPFT)	[redacted]	[redacted]		A	Y	A	Y	Y
	[redacted]	[redacted]		Y	Y	Y	Y	Y
	[redacted]	[redacted]		A	Y	X	Y	Y
North Staffs Combined Healthcare (NSCHT)	[redacted]	[redacted]		Y	Y	Y	Y	Y
	[redacted]	[redacted]		Y	A	Y	A	Y
SSOT ICB Associate Director: Medicines Optimisation	Amin Mitha	AM		Y	Y	Y	Y	Y
SSOT ICB Chief Pharmaceutical Officer	Mark Seaton	MSe		Y	Y	Y	A	Y
Stoke-on-Trent Place/CPL Leads	John Gilby	JG		Y	Y	A	Y	Y
	To be confirmed							
Staffordshire Place*/CPL Leads	[redacted]	[redacted]		Y	Y	Y	Y	Y
	[redacted]	[redacted]		A	A	A	A	Y
Black Country ICB/ICS	[redacted]	[redacted]		Y	A	A	A	X
Derby and Derbyshire ICB / ICS	[redacted]	[redacted]		X	X	Y	Y	X
	[redacted]	[redacted]		X	X	A	A	Y
Healthwatch	[redacted]	[redacted]		A	A	X	X	Y
Local Pharmaceutical Committee(s)	[redacted]	[redacted]		A	A	X	X	X
Local Medical Committee- North Staffordshire	[redacted]	[redacted]		A*	A*	A*	Y	A*
Local Medical Committee-South Staffordshire	[redacted]	[redacted]					Y	Y
Primary Care Nurse Lead	[redacted]	[redacted]		Y	Y	A	A	Y
IMOG Secretariat	Jane Rosam	JR		Y	Y	Y	Y	Y
	[redacted]	[redacted]		Y	Y	A	Y	Y
	[redacted]	[redacted]		Y	Y	Y	Y	Y

In attendance		Initials	10.01.2024
LMC Representative – North Staffordshire			**For LMC***
Senior Medicines Optimisation Pharmacist - SSOTICB			**Item 9**
Consultant Neurologist, UHNM			**Item 9**
Senior Medicines Optimisation Pharmacist - SSOTICB			**Item 11**
Interface Pharmacist - UHNM			**Items 9 & 11**
Medicines Optimisation Pharmacist - SSOTICB			**Item 14**
Community Cardiologist – MPFT (Secondment) (Cardiology Consultant – UHNM)			**Item 15**
Diabetes Specialist Team Consultant (UHNM) Consultant (UHNM) Weight Management Senior Manager			**Item 9 TA924 Tirzapatide**

**** Abbreviations and their meanings page 9***

1.0	**Welcome** MS welcomed everyone to the meeting and reminded all attendees of the Leadership Compact which had been agreed by all members and should be adhered to throughout the meeting.	
2.0	**Apologies** Apologies were noted as above. is due to co-present item 9 (Rimegepant for treating acute migraine) however, will be late joining as called to deal with an emergency situation.	
3.0	**Declarations of Interest and Actions to manage Conflicts.** There were none declared. A full and complete register of declarations for IMOG membership is kept on file with the secretariat.	
4.0	**Quoracy** The meeting was quorate.	
5.0	**Minutes of last meeting: 6th December 2023** The minutes of the meeting held on 6th December 2023 were **CONFIRMED** as a true and accurate record.	
6.0	**IMOG Action Tracker** **New Action - Osvaren** – reported that there is very limited usage of this product in renal medicine. Since 2021 there have only been 6 prescriptions dispensed. has asked UHNM Chief Dietician regarding the criteria and is awaiting response. **Action 18 - Dienogest new formulary application** – Due March 2024 **Action 16 - NaCl Sodium chloride oral solution in the use of paediatrics** - Item on the agenda **Action 15 - Penicillamine in Wilson's disease** - Item on the agenda **Action 13 - high risk medicines shortages** – IMOG agreed action is around process and can be closed.	

	Action 12 – clomifene – IMOG agreed action is around process and can be closed.	
7.0	**Decision register update** There was none for this month.	
8.0	**Outstanding Business from the previous meeting:** There was none for this month.	
9.0	**Health Economy NICE Implementation Group (HENIG)** [redacted] presented the item. HENIG Minutes – November 2023 Members **NOTED** the minutes. NHSE & ICB Funded- NICE TA summary. NHSE Funded TA931 Zanubrutinib for treating chronic lymphocytic leukaemia. TA934 Foslevodopa–foscarbidopa for treating advanced Parkinson's with motor symptoms. **Decision: The IMOG APPROVED Zanubrutinib and Foslevodopa–foscarbidopa as RED status and per HENIG recommendation.** ICB Funded TA922 Daridorexant for treating insomnia disorder. (Published 18th October) Recommended for treating insomnia in adults with symptoms lasting for 3 nights or more per week for at least 3 months, and whose daytime functioning is considerably affected, only if: cognitive behavioural therapy for insomnia (CBTi) has been tried but not worked, or CBTi is not available or is unsuitable. As there are currently no commissioned sleep behavioural services there has not been a clear route to gain expert opinion for this TA. In the absence of clear supporting information, the HENIG asks the IMOG to consider a temporary **RED** status for 3 months whilst further work is underway in the system to identify a care pathway for patients with long term insomnia and training from a specialist once one is identified. MS felt that general practice will probably see a huge number of requests coming through as there had been various reports in the press around this medicine. Although some practices have access to CBTi through the use of the Sleepstation app, most did not, and this was the underlying factor in the ability to safely prescribe. [redacted] commented that Sleepstation would be gone in March as there was no longer funding, leaving the ICB behind other areas that do have sleep services. [redacted] had concerns around these medicines and would not prescribe. As NICE TAs become mandatory after three months of publication [redacted] suggested it be clearly stated on the formulary that currently in SSoTICB there is no Commissioned service and that was something that needed to be explored.	



MS felt as there was no expertise or specialist service GPs would be under pressure to prescribe without the recommended specialist training. There was yet no route to access training which would be necessary for every frontline clinician. There was no reference as to who would assess if the patient was successfully responding to treatment, or otherwise, after 12 months.

echoed and comments that a commissioned sleep service was needed including CBTi. There is no longer a service for children either and children with sleep disorders, but no clear mental health issues, should not be coming through CAMHS.

pointed out that the TA does not mention the need for a commissioned service but does suggest Daridorexant should be offered if CBTi has been tried but not worked or if it's not available. suggested that for our health economy formulary if **RED** is agreed than a caveat be added “currently under review and pending status” instead of “no commissioned service available”. Also should this medicine be made available in primary care, primary care audits should be in place to monitor spend.

who was working with weight management service at the UHNM was asked for a view on new commissioned services. and commented that there was a sleep service however this was more around study and wasn’t a commissioned pathway linking various clinical areas such as sleep apnoea, neurology, psychological, respiratory issues. was concerned that once this was included in the formulary that someone would prescribe it with no infrastructure in place.

AM suggested that making the drug **RED** on the formulary would not solve the issues; data showed the drug was safe and there was no reason to make it a secondary care only drug. agreed it was the lack of infrastructure for effective and appropriate use. and agreed and there would not be a commissioned sleep clinic any time soon.

suggested helpful guidelines if it were to be prescribed in general practice alongside other drugs used for insomnia, melatonin being one of them, but not taking away the need for specialist services.

commented that some people do take matters in their own hands and order melatonin, cannabis oil etc online which is more dangerous than being assessed and prescribed a safe and effective well-studied drug, even if little is known about it.

suggested primary care could set up a group of those who have an interest and would like to explore more around sleep service. agreed and suggested asking for some advice from secondary care colleagues. queried how the training could be disseminated; he himself was interested in taking it forward, however, didn’t want to put other GPs, who didn’t have a particular interest, in an awkward situation with patients.

suggested offering an online accredited training module to PCN Leads and all clinicians including pharmacy colleagues and ANPs who can then disseminate learning to colleagues.

MS suggested agreeing to an interim RAG status while discussions around advice, specialist training availability etc. are sought for 6 months; and asked the group to agree on the interim status considering discussions around neither **RED** nor **GREEN** being entirely appropriate. **GREY** also inappropriate as this states a drug is available but not recommended for use.

	It was eventually agreed that there was currently no relevant RAG status to apply even with a narrative stating there are no specialist services and a new colour rating with agreed narrative would be required. As the implementation date is Tuesday 16th January the discussion will be taken outside of this meeting. **Action: ██ to explore appropriate training for all clinicians and bring back findings in 6 months. ████ to discuss a new suggested BLUE rating outside of the IMOG meeting.**	
	TA919 Rimegepant for treating acute migraine (Published 18th October) recommended as an option for the acute treatment of migraine with or without aura in adults, only if for previous migraines: at least 2 triptans were tried and they did not work well enough or triptans were contraindicated or not tolerated, and nonsteroidal anti-inflammatory drugs (NSAIDs) and paracetamol were tried but did not work well enough. During discussions capacity issues within primary and secondary care were acknowledged. However, from a safety aspect it may be suitable to initiate in primary care to prescribe for the acute treatment of migraine with a suggested **GREEN** status for acute treatment of migraine working alongside a pathway of care to refer patients to secondary care specialists should the number of tablets used per month exceed a set quantity of 8 x 75mg, and an **AMBER I** status for chronic use . There would also need to be a programme of education and training rolled out to primary care, this would be facilitated by UHNM neurologists via Protected Learning Time (PLT) sessions in primary care and primary care audits in place to monitor financial impact. Other agents, namely Triptans, were also available to prescribe to patients and that there should be robust guidance relating to the use of these in relation to newer agents such as Rimegepant as a whole. A formulary discrepancy between North and South formularies with regards to triptan was also pointed out. ██ raised that there have been several treatments approved via NICE over the last two to three years within neurology and raised concern around capacity. If capacity was becoming an issue UHNM needed to link in with Commissioners to understand how it can be addressed. ██ confirmed that this has already been flagged. AM queried primary care just using preventative medicines rather than referring to neurology specialists after a certain amount of Rimegepant tablets. MS referred to the NICE TA guidance which suggests referring in these cases. ██ questioned if specialist consultants could give robust advice and guidance to the patient; MS said that he was sure they wouldn't have an issue, it was GPs that had raised the concern. MS then suggested if concerns were raised in 12 months' time, once more experience is gained, a review for **AMBER R** with advice and guidance before requesting primary care prescribe, can be discussed. **Decision: IMOG APPROVED Rimegepant be added to the Staffordshire Formularies as GREEN for acute use and AMBER I for preventative use as per HENIG proposal** Papers for Migraine Medicines formulary and Rimegepant prevention update	

	TA906 were enclosed for information as discussed at the New Medicines Group. joined the call said candesartan, verapamil and lithium would be discussed at a later IMOG meeting. He had also put together an easy-to-follow guide for primary care to follow and was happy for referral back to specialists once the agreed 8 tablets a month point at been reached. also requested a discussion around adding Sumatriptan injection to the formulary as a matter of urgency. confirmed the FHG are reviewing triptans over the next couple of weeks to come to IMOG for approval.	
	TA924 Tirzapatide for treating type 2 diabetes (25th October) recommended for treating type 2 diabetes alongside diet and exercise in adults when it is insufficiently controlled only if: triple therapy with metformin and 2 other oral antidiabetic drugs is ineffective, not tolerated or contraindicated, and they have a body mass index (BMI) of 35 kg/m2 or more, and specific psychological or other medical problems associated with obesity, or they have a BMI of less than 35 kg/m2, and insulin therapy would have significant occupational implications, or weight loss would benefit other significant obesity- related complications. The addition of Tirzepatide to the formulary would add an additional option for treating type 2 diabetes and would be placed as an alternative to the established GLP-1 mimetics, in line with the guidance in the NICE TA A discussion was also held at the diabetes network meeting in November where (Consultant, UHNM) and (Consultant, UHNM) were present and supported the addition to the formulary of Tirzepatide as an **AMBER I** medication in line with the other GLP-1 mimetics. They wouldn't expect it to be used before the established GLP-1 mimetics but noted that the current stock issues may lead to it being used sooner in certain circumstances. AM queried if this this drug would be used more and more instead of GLP-1 and should there be caution and extra local requirement added to say that this drug should only be used if GLP-1s don't produce the required HBA1C* reduction and the required weight reduction. responded that NICE recommends at the same level as GLP- 1 not as the next step. Evidence from the SURPASS trials shows overwhelmingly that tirzepatide is more effective both in glucose control and weight reduction, then semaglutide, which was previously the market leader. It should be noted that there is a shortage of GLP-1 receptors at the moment and this could last 12 months. said that **AMBER I** would be acceptable as following the introduction of dapagliflozin, other GLP-1s were used less. proposes training is refreshed for UHNM and GPs with some supervision from Specialists who will then also able to initiate these drugs for their practice. Tirzepatide appears to be safe and side-effects similar to other antagonists but need to be cautious because it's so effective in glucose control, we may see retinopathy. asked for south-facing GPs to be included in any training as consistency was needed Countywide. agreed. **Decision: IMOG APPROVED the proposal of Tirzapatide be added to the Staffordshire Formularies as AMBER I.**	
10.0	**New Medicines Group**	
	Nothing for this month.	

11.0	**Formulary Harmonisation Group (FHG)** Chapter 9 NaCl (sodium chloride) – follow-up Carried forward to next meeting.	
12.0	**ESCA Task and Finish Groups** Nothing for this month.	
13.0	**Medicines Safety Group update** There were no updates this month.	
14.0	**Opioid Resources** Carried forward to next meeting.	
15.0	**Entreso/ sacubitril valsartan** [redacted] presented the item. Entresto is a drug that's had proven benefit in terms of improving quality and quantity of life in patients with heart failure with reduced ejection fraction since 2014. NICE TAs since 2016 and a NICE recommendation for chronic heart failure guideline from 2018, making it a familiar drug. Widely used and has been available for 10 years, however, the problem is capacity within the system for Specialist services in that it is an **AMBER I** drug and requires three months follow up for the specialist heart failure nurses. NICE recommend 6 specialist nurses per 100,000 population, in pan Staffordshire there are 9; 45 nurses are required to cope with demand. [redacted] proposes **AMBER R** for Entresto to integrate prescribing in primary care to free up specialist community heart failure nurses and deal with the more complex patients. [redacted] has put together a simple guide to initiate and titrate patients in primary care. [redacted] raised concerns that even though ACE inhibitors are safe drugs that Entresto initiation is not funded along with there being no mechanism in primary care to initiate and prescribe and patients won't be picked up after the two-day ACE washout period. [redacted] responded that in terms of initiating this drug, the two-day response is something that can be sorted out, but the idea is to get protocol in primary care for patients who are titrated and on optimal medical therapy already who get reassessed in terms of their LV function. If that is and remains below 35%, then it is a group recommended to go on to Entresto. The two-date washout/gap period shouldn't stop this from going forward as a system as a solution can be found for that. MPFT had seconded [redacted] from UHNM as a Community Cardiologist to work with the ICB as a system solution. [redacted] said that GPs shouldn't be forced to prescribe and inclusion on the formulary might do that. [redacted] said that this was not forced but a move within the ICS was necessary holistically. Additionally, the contract was with secondary care and not primary care; if the formulary status is changed as requested the funding to prescribe needed to be provided. Lengthy discussion took place and all GPs present were unanimous the proposal did not address capacity concerns with primary care at this time. [redacted] felt that letters asking to prescribe would put pressure on GPs. [redacted] said that mainly GPs were generalists and specialist knowledge was within secondary care. [redacted] argued that there may not be a resource issue in all practices and if there was that could be dealt with. [redacted] said that he had not seen any appetite coming through LMC to prescribe and which was more than likely due to capacity issues.	

	No firm conclusion could be reached regarding Entresto due to the capacity concerns expressed by both Secondary and Primary Care Providers. JR suggested taking the discussions to the system ELF Portfolio and newly formed CVS CIG to allow for the capacity concerns raised and the patient pathway redesign to be considered and supported in its totality. Then IMOG can consider how to dovetail any prescribing pathway redesign within the wider care pathway. █ asked if it could be noted his role as a Community Cardiologist involves coming into GP practices to help support the heart failure service and if anyone has a particular interest to please contact him direct. **Decision: IMOG DID NOT APPROVE the proposal for AMBER R for Entresto on the Staffordshire formularies & to request the ELF Portfolio and CVS CIG advise on appropriate next steps.**	
16.0	**JAPC - Bulletin November 2023** IMOG **NOTED** the bulletin.	
17.0	**Black Country IMOG Minutes – October 2023** IMOG **NOTED** the minutes.	
18.0	**Any Other Business** GLP-1 Shortages – AM provided an update from the national patient safety alert which recommends patients on Viktoza injections could be switched to semaglutide tablets which are **AMBER I** however, because of the shortages for viktoza asked if this could be managed in primary care. █ suggested adding the information and guidance in the GP Bulletin so that general practice make their own decision if they are comfortable doing so. **AM would take this as an ACTION.** Testosterone – █ raised that general practice are getting huge numbers of women requesting testosterone. █ confirmed the NMG application was due to be discussed at IMOG in February by formulary application leads from UHNM. In the meantime, it was agreed to add "For licensed Indications" by the drug name and in brackets, to all entries for testosterone in the North Staffs formulary and all entries for testosterone in the South Formulary.	
	The meeting closed at 16:14	
	Date of next meeting Wednesday 7th February 2024, 2.00-4.00pm via MS Teams	
	Meeting effectiveness: Have we upheld the behaviours agreed in the Leadership Compact? Any learning and how we can improve going forward?	**Y** **Y**

Staffordshire & Stoke-on-Trent System Leadership Compact

Trust

- We will be **dependable** we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency** working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be open to **changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness & Honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by Example

- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

ACEi = Angiotensin-converting enzyme inhibitors

Respects

- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to **understand** others' points of view and **empathise** with

Kindness & Compassions

- We will show **kindness**, **empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion.**

System First

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire & Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative

Looking Forward

- We will focus on **what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a

JAPC = Joint Area Prescribing Committee
ACS = acute coronary syndromes
ADHD= Attention-deficit/hyperactivity disorder APC/G = Area Prescribing Committee/Group ESCA = effective shared care agreement RAG = red, amber, green
AHSN = Academic Health Science Network
Blueteq = a web-based software system for the approval and management of high-cost medicines across a range of healthcare conditions
BNP = a blood protein B-type natriuretic peptide (BNP) and N-terminal-pro-BNP (NT-pro-BNP).
CGRP = Calcitonin Gene-Related Peptide
CBTi = Cognitive Behavioural Therapy for Insomnia
CPAG = Clinical Priorities Application Group
CVD – cardiovascular disease
AST = aspartate transaminase
ALT = alanine transaminase
CYP = children and young people's portfolio
DMARD = disease-modifying anti-rheumatic drug
DMH = Douglas Macmillan Hospice
ELF = End of life, long term conditions & Frailty
F&P = Finance & Performance Committee
FHG = Formulary Harmonisation Group
BMI = Body Mass Index
HbA1c = glycated haemoglobin
HF = Heart Failure
HFpEF = Heart Failure with Preserved Ejection Fraction
I = Initiate
LMC = Local Medical Committee
LVEF = Left ventricular ejection fraction
MDT – Multi Disciplinary Team
Mims = Monthly Index of Medical Specialties
SRO = Senior Responsible Officer
MO = Medicines Optimisation
BNF = British National Formulary
NaCl* = sodium chloride oral solution
NEDs = Non-Executive Directors
NICE = National Institute for Health & Care Excellence
HENIG = Health Economy NICE Implementation Group
ICB = Integrated Care Board
NPSA = national patient safety alert
NYHA = New York Heart Association
IV =intravenous
PCN DES = primary care network direct enhanced service
pMDI = pressurized metered dose inhaler
PSDs = patent specific directions
R = Recommend
RMOC = Regional Medicines Optimisation Committee
STAC = Staffordshire thrombosis & anticoagulation centre
QRISK = a prediction algorithm for cardiovascular disease
LTC = Long Term Conditions
SHINE = a nurse led service providing advice, education, assessment and treatment for patients with heart failure
SPC = Suprapubic Catheter
TA= Technology Appraisal
UHNM = University Hospital North Midlands
MPFT = Midlands Partnership Foundation Trust
NSCHT = North Staffs Combined HealthcareTrust
GLP = glucagon-like peptide