TAM SUBGROUP OF THE NHS HIGHLAND AREA DRUG AND THERAPEUTICS COMMITTEE

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MINUTE of meeting of the TAM Subgroup of NHS Highland ADTC
25 June 2020, via Microsoft TEAMS

Present:	Okain McLennan, Chair Findlay Hickey, Lead Pharmacist (North & West) Patricia Hannam, Formulary Pharmacist Dr Robert Peel, Consultant Nephrologist Dr Antonia Reed, GP Clare Bagley, Senior MM&I Pharmacist, Raigmore Louise Reid, Acute Pain Nurse Joanne McCoy, LGOWIT Co-ordinator Dr Duncan Scott, Clinical Lead, TAM Margaret Moss, Lead AHP, North & West Division Emer Friel, Pharmacist Western Isles (Deputy for Liam Callaghan)
In attendance:	Wendy Anderson, Formulary Assistant
Apologies:	Dr Jude Watmough, GP Liam Callaghan, Principal Pharmacist Western Isles

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

No interests were declared.

3. MINUTES OF MEETING ON 23 APRIL 2020

Accepted as accurate.

4. FOLLOW UP REPORT

A brief verbal update was given. The following in particular was highlighted:

- Desmopressin would not be added to the Formulary until the outstanding action had been resolved.
- The Paediatric Formulary discussion was still ongoing. Mairi Dunbar in initial stage with trying to set up Highland Paediatric Medicines Management Group with the involvement of David Goudie. It was envisaged that it would form a stand-alone group similar to the Antimicrobial Management Team and this should be put to ADTC for discussion.

5. CONSIDER FOR APPROVAL ADDITIONS TO FORMULARY

5.1. Rivaroxaban 2·5mg film-coated tablets (Xarelto)
Submitted by: Bernhard Wolf, Consultant General and Vascular Surgeon
Indication: As per SMC2128: Co-administered with aspirin for the prevention of atherothrombotic events in adult patients with: coronary artery disease (CAD) or symptomatic peripheral artery disease (PAD), at high risk of ischaemic events.
Comments: A multi-disciplinary team were consulted regarding this submission with input from Cardiology. A very small amount of people will be treated but treatment group needs to be extremely targeted as the risk of harmful effects are high. Cost reduction will depend on intervention with no difference between the groups and the burden for prescribing should not fall to Primary Care. Unclear who will be making the decision to prescribe and strongly felt that, as there is a high risk of using this treatment,

it should be specialist use only. The submission needs to be changed to this from General Practice. Agreed that it was not unreasonable to go back to requestor and ask for guidance/criteria.
PENDING above
Action

5.2. Fampridine 10mg tablets (Fampyra)
Submitted by: Francisco Javier Carod Artal, Consultant Neurologist
Indication: As per SMC2253: For the improvement of walking in adult patients with multiple sclerosis with walking disability (EDSS [expanded disability status scale] 4-7).
Comments: Previously rejected but now available via Patient Access Scheme. Approximately 37 patients currently receiving this treatment via homecare. Clear criteria in place, particularly on stopping treatment. However, clarification required on who initiates treatment – primary or secondary care and where assessments are carried out – by physiotherapists?
ACCEPTED pending above
Action

5.3. Daratumumab 1800mg/15ml solution for injection (Darzalex)
Submitted by: Peter Forsyth, Consultant Haematologist
Indication: New formulation of SMC approved therapy SMC1205/17: As monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, whose prior therapy included a proteasome inhibitor and an immunomodulatory agent and who have demonstrated disease progression on the last therapy.
Comments: This submission did not have SMC approval and routinely would have been discussed at ADTC. Due to current COVID situation ADTC meetings were suspended and therefore the Group agreed to discuss. This formulation will reduce patient/clinician contact as subcutaneous rather than IV route of administration. It was assumed that as no price difference SMC would approve. There would be advantages in resource utilisation in Raigmore, however there needed to be amendments made to the Systemic Anti-Cancer Treatment (SACT) protocol to clarify the different practices needed in the District and the Rural General Hospitals.
ACCEPTED
Action

5.4. Obeticholic acid 5mg and 10mg tablets (Ocaliva)
Submitted by: Dr Broad, Consultant Gastroenterologist
Indication: As per SMC1232/17: Primary biliary cholangitis (also known as primary biliary cirrhosis) in combination with ursodeoxycholic acid in adults with an inadequate response to ursodeoxycholic acid or as monotherapy in adults unable to tolerate ursodeoxycholic acid.
Comments: Limited treatment options available for this rare condition. As only very small numbers of patients it will be under very tight scrutiny. The intent for prescribing needs to be specified including who takes responsibility for starting/stopping/monitoring, will this fall to primary care? This must be included in any guidance available.
ACCEPTED
Action

6. UPDATED AND NEW HIGHLAND FORMULARY SECTIONS AND GUIDANCE FOR APPROVAL

6.1. Hyponatraemia *(updated)*

- Of benefit to include the introduction text on the old version into the new version.
- Difficult to read very small text within the boxes – format to make bigger.
- Step 2 – list of medicines referred to is missing and needs to be added.
- Aimed very much at the hospital setting and needs to be adapted to include referral criteria for primary care.
- National guidance link from the checklist to be included on the guidance.

ACCEPTED pending above
Action

6.2. **MUST guidance *(resubmission from May 2019 meeting)***

- Include a link to the MUST scoring sheet or include text stating as per nursing document.

ACCEPTED pending above
Action

6.3. **Recurrent UTIs in females *(resubmission from April meeting)***

- Query requirement for scan after 2 UTIs in 6 months. Is this requirement correct?
- Send link to EF to comment on, as unable to view prior to meeting.

ACCEPTED pending above

Action

7. GUIDANCE FOR NOTING ONLY (REVIEWED AND NO CHANGES MADE)

A clinical governance checklist should be completed by lead reviewers for any piece of guidance on future agendas and be included with the relevant meeting's papers.

8. HOMECARE REPORT

This report was instigated following on from the last Subgroup meeting where it had been identified that a number of Dermatology medicines currently used were not on the Formulary and a submission had never then made. This report flagged up that a number of treatments currently provided by the Homecare service were not on the Formulary. Currently they were being managed by the Homecare system with them taking responsibility for keeping appropriate records, however it lacks the Formulary governance oversight.

PH and Pharmacy Lead for Homecare to liaise and retrospective departmental submissions for SMC approved Homecare medicines are to be made. A comment will be added to the appropriate Formulary monograph stating that Homecare is the preferred option and include who to contact. Future medicines suitable for Homecare, that are SMC approved, will undergo Formulary submission. It was agreed that patient numbers would not be the criteria for submission. To prevent 'indication creep' a minor amendment will be made to provide a record when a Formulary Homecare medicine is to be used for a new indication.

A better route for rare conditions and non-SMC approved medicines would be as other than Formulary processes such as IPTR, etc.

Action

9. CLINICAL EXPERTISE GROUP RELATIONSHIP WITH TAM AND GOVERNANCE

The Clinical Expertise Group (CEG) was set up to deal with rapid turnaround of guidance following COVID-19. TAM agreed to act as a conduit to share COVID-19 therapeutic information. Initially a 3 month review date had been set on all guidance ratified by CEG and uploaded on to TAM. A robust review process needs to be put in place to ensure appropriate governance regarding review of said guidance. PH is raising this with Clinical Governance and CEG.

Wider issue of how CEG will fit into the current governance structure, including the TAM subgroup. A number of questions were raised:

- How will CEG and TAM subgroup work together and what will the division of duties be, eg, will CEG continue to look at COVID-19 and rapid turnaround guidance with TAM looking at non-rapid turnaround?
- Where does it sit within Clinical Governance and how will it link with ADTC?
- The Area Clinical Forum has already had similar discussion and suggests that the current CEG terms of reference are short and limited and need to be reviewed against ACF constitution. Is there any collaboration?
- What are the future intentions of CEG?
- What governance structure does it have?
- Is CEG sustainable? It is acknowledged that there is currently much clinician engagement, but will this continue, and also acknowledged that other, longer-standing groups, have lacked such clinician engagement – who and why?
- How should other Groups continue if CEG becomes permanent?

TAM subgroup remit has been recently updated however it is to be circulated to the Group again for review to ensure that its aims and objectives are clear and unambiguous in preparation to any review of governance groups in NHS Highland. CEG governance documents are to be circulated for information.

CEG has hugely increased clinical engagement in guidance review and there is a need for CEG, however, the general consensus was that there was a lack of confidence that it follows governance standards appropriately. The agenda and meeting dates can be fluid and sometimes items on it need more thought/discussion than time allows at CEG. Not always the most appropriate avenue for ratification. It has over 40 members on the

Group but is missing group representation from some areas. CEG is not a governance structure group for the Board and does not fit under set criteria. Governance needs to be addressed and be more robust with a clearly defined role of what CEG is.

Seek clarity on overall governance of CEG and how it is going to move forward and engage with other existing groups eg ADTC. What do we need as opposed to what do we have approach should be raised with ADTC.
Action

10. RECOMMENDATIONS FOR MINOR ADDITIONS/DELETIONS/AMENDMENTS

Noted.

11. SMC ADVICE

SMC has been suspended in March because of COVID. There is a large backlog, but things are now starting to resume with the New Drugs Committee due to meet via TEAMS next week. SMC, is working with NICE to develop Zoom for its meetings with potentially the next meeting being held in August. A decision has been made to give a 'light touch' on some submissions (SMC executive group review) in order to process them through the system more quickly and bypass the SMC bottleneck. The knock effect of this for this Group could mean an increase in submissions in the short term as the backlog is cleared by SMC.

12. FORMULARY REPORT

This was a very price focussed report. Reports can be produced at Practice level and this was thought to be useful and desirable. Work was currently under way to set up a process whereby individual practice level reports could be sent out on a quarterly basis directly to the GP Practices. Felt this would be desirable in the longer term but given the current circumstances and heavy workload was suggested that this not be done at this precise time.

A report was also possible for Western Isles and it was agreed to provide this information to LC and EF.
Action

13. TAM REPORT

A new style of report had been developed pulling information from Google Analytics. This showed a trend that out of date guidance is reducing in numbers. An annual report will be presented to the Group which will also be submitted to ADTC. It will also be shared with Clinical Governance as a flag and they would be asked for suggestions/support following on from this.

14. FORMULARY AND TAM SURVEY

Traditionally a paper version of the survey was sent out every 2 years. This proved time onerous and trial of an electronic version using the Survey Monkey platform was devised with the link being sent to all *the* Pink One distribution and promoted on TAM. Uptake has not been nearly as high as the paper version, however good responses over a multiple-disciplinary range had been received. Comments are currently being considered and actioned. It was suggested that the way forward for feedback/survey take the form of every month 5 surveys be randomly sent out, similar to the process that the Medicines Information Team followed as a Key Performance Indicator.

A report would be written and circulated to the Group on feedback that had been received from this current survey.
Action

15. NHS WESTERN ISLES

Nothing to report.

16. AOCB

Patient information provision on TAM

Concern raised over the content of the Patient Information section as it includes many locally produced leaflets and it is not clear which have been through the appropriate governance. It was suggested that TAM should promote the use of 'National or NHS approved' information resources and locally produced information would be removed. Suggested that any appropriately governed locally prepared leaflets should sit on department own page on TAM. It was not the intention of the Group to restrict information but instead to ensure provision of quality resources that were not detrimental. PH has been liaising with Clinical Governance, Speech and

Language and Disability Learning with little progress. This issue had been clearly raised on several occasions with Clinical Governance and it does not fall within this Group's remit. JM agreed to discuss this further with PH.

Action

TAM training video

A video aimed at induction for Junior Doctors and other NHS staff was currently being developed by the TAM team. There will also be a Learnpro module. It had hoped that a draft would be ready, but as this had not been the case it would be provided at a future meeting. First draft to be shared with DS for review prior to being discussed at TAM Subgroup.

Action

17. DATE OF NEXT MEETING
Next meeting to take place on Thursday 27 August from 14:00-16:00 via Microsoft TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Rivaroxaban *Back to minutes*	June 2020	Clarification required on who will be making the decision to prescribe and strongly felt that, as there is a high risk of using this treatment, it should be specialist use only. The submission needs to be changed to this from General Practice. Further guidance/ prescribing criteria required.	**PH**
Fampridine *Back to minutes*	June 2020	Clarification required on who initiates treatment – primary or secondary care? Where are assessments carried out – done by physiotherapists?	**PH**
Daratumumab *Back to minutes*	June 2020	Request amendments to the SACT protocol to clarify the different practices in the District and the Rural General Hospitals.	**PH**
Obeticholic acid *Back to minutes*	June 2020	Clarification is needed as to who has the responsibility for starting/monitoring/review. If this is to be the responsibility of the GP, guidance is to be provided to support this as there will be limited information available in primary care for this rare condition.	**PH**
Hyponatraemia *Back to minutes*	June 2020	Inform requester of amendments to be made.	**PH**
MUST Guidance *Back to minutes*	June 2020	Inform requester of amendments to be made.	**PH**
Recurrent UTI in females *Back to minutes*	June 2020	Inform requester of amendments to be made.	**PH**
Homecare report *Back to minutes*	June 2020	Liaise with Pharmacy Lead for Homecare to put for retrospective submission any SMC approved Homecare medicines broken down departmentally.	**PH**
Clinical Expertise Group relationship with TAM and Governance *Back to minutes*	June 2020	Circulate remit again and any other CEG guidance documents to the Group. Submit request to ADTC for CEG governance structure to be clarified.	**PH/WA**
Formulary report *Back to minutes*	June 2020	A report specific to Western Isles to be provided to LC and EF.	**FH**
Formulary and TAM survey *Back to minutes*	June 2020	A report to be written and circulated to the Group on feedback received from this current survey.	**PH**
Patient information provision on TAM *Back to minutes*	June 2020	Review Patient Information Section.	**PH/JM**

TAM training video *Back to minutes*	June 2020	First draft to be shared with DS for review prior to being discussed at TAM Subgroup.	**PH/DS**