# 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**
**30 June 2022, via Microsoft TEAMS**

| | |
|---|---|
| **Present:** | Alasdair Lawton, Chair<br>Patricia Hannam, Formulary Pharmacist<br>Dr Antonia Reed, GP<br>Dr Robert Peel, Consultant Nephrologist<br>Dr Alan Miles, GP<br>Louise Reid, Acute Pain Nurse Lead<br>Dr Jude Watmough, GP<br>Joanne McCoy, LGOWIT Co-ordinator<br>Linda Burgin, Patient Representative<br>Liam Callaghan, Chief Pharmacist, NHS Western Isles<br>Jenny Munro, AP Physiotherapist, Continence and Independent Prescriber<br>Damon Horn, HEPMA Pharmacist<br>Wendy Smith, Patient Representative |
| **In attendance:** | Wendy Anderson, Formulary Assistant<br>Donna Fraser, TAM Project Support Manager<br>Rebecca McKenzie, Team Lead Vaccinations and CTAC Primary Care Clinic |
| **Apologies:** | Findlay Hickey, Principal Pharmacist (Medicines Management and Prescribing Advice)<br>Dr Simon Thompson, Consultant Physician<br>Dr Duncan Scott, Consultant Physician<br>Jane Smith, Principal Pharmacist |

## 1. WELCOME AND APOLOGIES

The Chair welcomed the group.

## 2. REGISTER OF INTEREST

No interests were declared.

## 3. MINUTES OF MEETING HELD ON 28 APRIL 2022

Accepted as accurate.

## 4. FOLLOW UP REPORT

A number of items had now been completed and a verbal update was given with the following points of particular note:

- The chronic pain guidelines will be submitted to the August subgroup.
- Relating to the urgent suspected lung cancer guidance, a guideline on how to refer will be submitted to the August subgroup.
- Spirometry – dissemination to the GPs has taken place via the Practice Managers.

## 5. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

**5.1. Metyrapone (Metopirone®) 250mg capsules (not submitted to the SMC)**
**Submitted by:** Joan MacKintosh, Clinical Pharmacist Team Manager
**Indication:** From SPC: A diagnostic aid in the differential diagnosis of ACTH-dependent Cushing's syndrome. The management of patients with Cushing's syndrome. In conjunction with glucocorticosteroids in the treatment of resistant oedema due to increased aldosterone secretion in patients suffering from

cirrhosis, nephrosis and congestive heart failure.
**Comments:** For use under specialist recommendation. The Consultant will give the relevant information to the GP. Monitoring and review will be done in the hospital setting; this information will be added to the Formulary monograph.
**ACCEPTED**

**5.2. Tirbanibulin (Klisyri®) 10mg/g ointment (SMC2395)**
**Submitted by:** Joan MacKintosh, Clinical Pharmacist Team Manager
**Indication:** Field treatment of non-hyperkeratotic, non-hypertrophic actinic keratosis (Olsen grade 1) of the face or scalp in adults.
**Comments:** Currently dermatology patient pathways are followed. As this particular medicine is not included, suggest that it is added on review.
**ACCEPTED**
**Action**

**5.3. Abrocitinib (Cibinqo®) 50mg, 100mg, and 200mg film-coated tablets (SMC2431)**
**Submitted by:** Joan MacKintosh, Clinical Pharmacist Team Manager
**Indication:** For the treatment of moderate-to-severe atopic dermatitis in adults and adolescents 12 years and older who are candidates for systemic therapy.
**Comments:** There is no clinical guideline to go along with this however this is acceptable due to it being such a specialist area.
**ACCEPTED**

**5.4. Dupilumab (Dupixent®) 200mg solution for injection in pre-filled syringe, 200mg solution for injection in pre-filled pen, 300mg solution for injection in pre-filled syringe, 300mg solution for injection in pre-filled pen (SMC317)**
**Submitted by:** Catriona Wheelan, Lead Pharmacist Respiratory and Gastroenterology
**Indication:** Adults and adolescents over 12 years old, as add on therapy for severe asthma with type 2 inflammation characterised by raised eosinophils ≥150cells/ microliter and raised fraction of exhaled nitric oxide FeNo≥25 parts per billion and ≥4 exacerbations in the preceding year who have previously received biologic therapy with anti-IGE or anti-IL-5 therapies.
**Comments:** This is the first drug licenced for this indication. Data effectiveness? States statistically significant improvement in FEV1 but it does not say if it is clinically significant and only speculates that it was. They also say that there is a statistically significant reduction in hospital admissions which is part of the justification for the cost, however they don't stipulate how many admissions. As there is a potential cost implication, escalate to Raigmore Finance department.
**ACCEPTED**
**Action**

**5.5. Levofloxacin (Quinsair®) 240mg nebuliser solution (SMC1162/16)**
**Submitted by:** Catriona Wheelan, Lead Pharmacist Respiratory and Gastroenterology
**Indication:** The management of chronic pulmonary infections due to Pseudomonas aeruginosa in adult patients with cystic fibrosis.
**Comments:** Three drug alternatives are listed but one of them, aztreonam lysine, is not on the Formulary; request a submission be made for this.
**ACCEPTED**
**Action**

**5.6. Mexiletine (Namuscla®) 50mg, 100mg, 200mg capsules (not submitted to the SMC for this indication)**
**Submitted by:** Peter Clarkson, Consultant Cardiologist
**Indication:** Ventricular Tachycardia which, in the judgement of the physician, are considered life threatening.
**Comments:** Now a licensed medicine. For restricted specialist use only.
**ACCEPTED**

**5.7. Ranolazine (Ranexa®) 375mg, 500mg and 750mg prolonged release tablets (there is no SMC submission for this indication)**
**Submitted by:** Peter Clarkson, Consultant Cardiologist
**Indication:** Ventricular arrhythmias.
**Comments:** Addition would make NHS Highland come in line with other cardiology departments which currently use it. It is good to have as a final option to a very niche number of patients. The only evidence provided is via Up-to-date (which is specialist opinion only) however this is a recognised treatment as a therapy of last resort and the cost implications are negligible.
**ACCEPTED**

**5.8. Fluocinolone acetonide (Iluvien®) 190 micrograms intravitreal implant (SMC2260 – Uveitis indication, 2020 and SMC864/13 – DMO indication, 2014)**

**Submitted by:** Dr David Knight, Consultant Ophthalmologist

**Indication:** Prevention of relapse in recurrent non-infective uveitis affecting the posterior segment of the eye.

Chronic diabetic macular oedema, considered insufficiently responsive to available therapies, in pseudophakic eyes.

**Comments:** This will relieve the burden of patients having to attend so much as the interval between treatments is longer.

**ACCEPTED**

## 6. UPDATED AND NEW TAM GUIDANCE FOR APPROVAL

**6.1. Management of hypercalcaemia**

- Generally a good document but who is it aimed at? Agreed to add 'In-patient' to the title.
- What is the referral criteria to get to the guideline and what is the escalation process?
- The examination process should come before the management.
- Under initial management, GCS is listed – is this really used?
- Under initial management, what does fluid status mean?
- Request that separate primary care guidance be written.

**REJECTED**

**Action**

**6.2. Investigation, treatment and referral of gastrointestinal conditions**

- A very confusing, long document that is of no value on TAM and is more for internal use only.

**REJECTED**

**Action**

**6.3. Sativex Shared Care Protocol**

- This will be renamed as a guideline and essential information only will remain.

**ACCEPTED**

**Action**

**6.4. Perioperative management of amputation pain in Raigmore Hospital**

- Nice, very didactic guidance.
- Should the rewritten neuropathic pain guidance reflect that pregabalin is first line and nortriptyline second line as per this guidance?

**ACCEPTED**

**Action**

**6.5. Baricitinib for adults and children aged 2 years and older admitted to hospital with confirmed SARS-CoV-2 infection**

- Dose reductions in kidney disease – eGFRs are listed for under 18s, which are invalidated in this age group. They have not been specific as to which formula; do they mean calculated GFRs? Very wide age ranges have been used. Also what formula are they using for the over 18s – is it Cockcroft and Gault? Signposts to formulas would be helpful.

**ACCEPTED**

**Action**

**6.6. Venous Thromboembolism Prophylaxis (VTEp) in COVID-19 adult medical inpatients**

**ACCEPTED**

**6.7. Fertility Clinic**

- These are Grampian guidelines that have been slightly 'Highlandised' and are aimed at Primary Care.
- Noted that they were helpful.
- There is a lot of information on the website that they request the patient looks at before referral so this should be added.
- COVID vaccination clarity needs to be included.

**ACCEPTED pending**

**Action**

**6.8. NHS Highland referral guidelines for faecal incontinence**

- Intended for use in Primary Care.
- Loperamide, fybogel and yoghurt combination is recommended – is there an evidence base for this or should anecdotally be added?
- Confirm the red flag warnings are the same as in the Colorectal guidelines (item 6.9).

**ACCEPTED pending**

**Action**

**6.9. Colorectal guidelines**

- This is a department suite of guidance.
- Remove any irrelevant bits from the document including the list of staff. These can be hosted on the intranet with a link only to it sitting on TAM. Suggest that for patients requiring access this departmental information could be hosted on the new NHS website.
- The document will be split down into more manageable sections for uploading to TAM.
- The appendices at the end, including graphs etc is background information only and will not be put on to TAM.
- Resubmit to August meeting for information once uploaded to TAM.

**ACCEPTED pending**

**Action**

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

Noted:
Endocarditis – Use of Echocardiography in Staph aureus Bacteraemia
COVID Fingers & Toes (including post COVID chilblains)

## 8. GUIDELINE MINOR AMENDMENTS

Noted and approved.

## 9. TAM REPORT

Donna Fraser provided an update. The number of out of date guidelines is being actively worked on and they are reducing in number. Point of note: the COVID-19 guideline section was reviewed last week and a number of guidelines have been archived.

## 10. TAM PROJECT CLOSURE REPORT

In summary there were 3 main objectives:

- ***Clinical Guidelines***
  A lot of work on reducing out of date guidance has taken place. Departmental review information is being given to service managers on an annual basis as it is their task to request that their department's information is up-to-date. This information also allows a gap analysis as to what is required.
- ***Patient information***
  It is now realised that this should be held separately to TAM. Hosting large amounts of patient information, such as the respiratory resource hub, clogs up the search function of TAM. This has also been realised at a national level where separate clinician and patient facing sites is the way forward. NHS Highland Webpages are being redeveloped and this patient-facing site could be the home for patient information going forward. The lack of clinical governance for patient information has been raised to the Clinical Governance Committee. TAM have been working with the Health Information Resource Service (HIRS) who have agreed to take over patient information. As a test of change they have been tasked to collate patient information and ensure that the governance is done for it. Clinical Governance will impose the governance but HIRS will request that the governance is followed. Essentially departments will still be responsible for producing their own patient information but they would be given the support, such as being provided with the tools and resources to enable quality patient information to be developed. HIRS will store it and flag reviews and be able to identify if multiple departments have patient information for the same treatment or condition.
- ***Referral information***
  There is a group within NHS Highland looking at referrals and TAM will work with this group to ensure that all referrals align with SCI Gateway and that SCI Gateway is recommended as the standard process for referral.

An establishment review has also been carried out; currently there is only one member of staff employed on TAM which is not sustainable going into the future. An options appraisal will be completed.

**11. COMPRESSION HOSIERY FORMULARY**

Noted and approved. This is part of a larger piece of work of moving formulary elements from the intranet to TAM to enable staff working in the community access to information.

**12. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS**

Noted and approved. These were mostly part of formulary revision, standardising the monograph entries, removing brand names and adding alerts.

**13. FORMULARY REPORT**

Noted. All items listed on the non-formulary report are being targeted to investigate why then are being prescribed and if it is appropriate should they be added to the formulary.

**14. SMC ADVICE**

Noted that, although there has been interest, there has to date been no formulary submission for liraglutide (Saxenda). Jenny Munro will take this forward within AHP to develop a formulary submission.

**ACCEPTED pending**

**Action**

**15. ENVIRONMENT**

A project has been funded and is currently being set up to do with the environment. Primary care are slowly switching inhalers to dry powder from aerosols.

**16. NHS WESTERN ISLES**

Liraglutide has been sent to the dietitians and it has been discussed at the local ADTC.

**17. ANY OTHER COMPETENT BUSINESS**

***SMC membership***

If anyone would like to nominate themselves please contact Findlay in the first instance.

***Shared Care Protocols***

The Policy for Shared Care was discussed at ADTC and it was agreed at that meeting that there was no popularity for shared care protocols. The policy will be rewritten with a view for how shared care is managed in NHS Highland, removing the emphasis on the outcome being a shared care protocol.

The Formulary submission form will be updated to remove the question regarding shared care protocols.

**Action**

***Query re Vision Formulary***

Should hospital use only drugs be included on the GP prescribing system by ticking the F box? They are Formulary but GPs would not be expected to prescribe them.

The prescribed elsewhere is useful as it gives all the interactions and the ECS is correct. Would prefer if they are not added as Formulary.

**18. DATE OF NEXT MEETING**

Next meeting to take place on Thursday 25 August, 14:00-16:00 via TEAMS.

**Actions agreed at TAM Subgroup meeting**

| Minute Ref | Meeting Date | Action Point | To be actioned by |
|---|---|---|---|
| Tirbanibulin (Klisyri®) 10mg/g ointment<br>*Back to minutes* | June 2022 | Currently dermatology patient pathways are followed, which this is not included in. Suggest that on review this is included. | **PH** |
| Dupilumab (Dupixent®) 200mg solution for injection in pre-filled syringe, 200mg solution for injection in pre-filled pen, | June 2022 | As there is a potential cost implication, escalate to Raigmore Finance department. | **PH** |

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|---|---|---|---|
| 300mg solution for injection in pre-filled syringe, 300mg solution for injection in pre-filled pen<br>*Back to minutes* | | | |
| Levofloxacin (Quinsair®) 240mg nebuliser solution<br>*Back to minutes* | June 2022 | Request a submission be made for aztreonam lysine. | **PH** |
| Management of hypercalcaemia<br>*Back to minutes* | June 2022 | • There is a lot of information on the website that they request the patient looks at before referral so this should be added.<br>• Add in-patient to the title.<br>• Request primary care guidance to be added including referral information from primary to secondary care.<br>• Referral information should therefore be rewritten as 'escalation'.<br>• The examination process should come before management.<br>• Under initial management query if GCS is actually used.<br>• Query what the phrase 'fluid statement' actually means. | **PH** |
| Investigation, treatment and referral of gastrointestinal conditions<br>*Back to minutes* | June 2022 | A very confusing, long document that is of no value on TAM and is more for internal use only. | **PH** |
| Sativex Shared Care Protocol<br>*Back to minutes* | June 2022 | This will be renamed as a guideline and essential information only will remain. | **PH** |
| Perioperative management of amputation pain in Raigmore Hospital<br>*Back to minutes* | June 2022 | Should the rewritten neuropathic pain guidance reflect that pregabalin is first line and nortriptyline second line as per this guidance? | **PH** |
| Baricitinib for adults and children aged 2 years and older admitted to hospital with confirmed SARS-CoV-2 infection<br>*Back to minutes* | June 2022 | Dose reductions in kidney disease – eGFRs are listed for under 18s, which are invalidated in this age group. They have not been specific as to which formula; do they mean calculated GFRs? Very wide age ranges have been used. Also what formula are they using for the over 18s – is it Cockcroft and Gault? Signposts to formulas would be helpful. | **PH** |
| Fertility Clinic<br>*Back to minutes* | June 2022 | • There is a lot of information on the website that they request the patient looks at before referral so this should be added.<br>• COVID vaccination clarity needs to be included. | **PH** |
| NHS Highland referral guidelines for faecal incontinence<br>*Back to minutes* | June 2022 | • Loperamide, fybogel and yoghurt combination is recommended – is there an evidence base for this or should anecdotally be added?<br>• Confirm the red flag warnings are the same as in the submitted Colorectal guidelines. | **PH** |
| Colorectal guidelines<br>*Back to minutes* | June 2022 | Resubmit to August meeting for information once uploaded to TAM. | **PH** |
| Any other competent business – Shared Care Protocols<br>*Back to minutes* | June 2022 | Remove the question regarding shared care protocols from the Formulary submission form. | **PH** |