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
27 April 2023, via Microsoft TEAMS

Present:	Alasdair Lawton, Chair Patricia Hannam, Formulary Pharmacist Findlay Hickey, Principal Pharmacist (Medicines Management and Prescribing Advice) Dr Duncan Scott, Consultant Physician Dr Jude Watmough, GP Dr Robert Peel, Consultant Nephrologist Dr Alan Miles, GP Claire Wright, Acute Pain Nurse Louise Reid, Acute Pain Lead Nurse Catriona Wheelan, Lead Pharmacist Respiratory and Gastroenterology Damon Horn, HEPMA Pharmacist Liam Callaghan, Chief Pharmacist, Western Isles Hospital
In attendance:	Wendy Anderson, Formulary Assistant Laura Cuthbertson, TAM Project Support Manager Dr Steven McCabe, Clinical Director (items 5.5 and 12.4)
Apologies:	Dr Antonia Reed, GP

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

FH made a declaration of interest for abemaciclib (item 5.2) – personal, non-specific interest in Eli Lilly.

3. MINUTES OF MEETING HELD ON 23 February 2023

Minutes accepted as accurate.

4. FOLLOW UP REPORT

A brief verbal report was provided.

ADHD Pilot Pathway

Comment was made that a timescale for them to review it was needed along with a commitment that they will not reject referrals that haven't included all the referral criteria. They need to be realistic about it and it is something that they could commit to even if they don't overhaul the guidance immediately.

5. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

5.1. Haematology Chemotherapy formulary submissions

No submissions received.

5.2. Oncology Chemotherapy formulary submissions

DH joined the meeting. All accepted.

Drug (name, form, strength and manufacturer)	SMC number & status
Abemaciclib (Verzenios®) 50mg, 100mg and 150mg tablets Eli Lilly and Company	SMC2135 05/04/19 – full submission. Accepted for use. SMC2494 04/11/22 – full submission. Accepted for use.

	Pralsetinib (Gavreto®) 100mg hard capsules Roche Products Limited	SMC2496 10/02/23 – full submission assessed under the end of life medicine process. Accepted for use on an interim basis subject to ongoing evaluation and future reassessment
	Tivozanib (Fotivda®) 890 micrograms and 1,340 micrograms hard capsules Eusa Pharma Limited	SMC1335/18 08/06/18 – full submission assessed under the end of life process. Accepted for restricted use.

5.3. Solriamfetol (Sunosi) 75mg and 150mg film-coated tablets (SMC2439)
Submitted by: Joan MacKintosh, Clinical Pharmacist Team Manager
Indication: To improve wakefulness and reduce excessive daytime sleepiness in adult patients with narcolepsy (with or without cataplexy). SMC restriction: For use in patients who have failed modafinil or have a contraindication or intolerance to modafinil.
Comments: To be used second line after modafinil. Where does this fit into the overall strategy? Clarify place in therapy. Recommend that it follows dexamfetamine and methylphenidate as it is not cost minimising versus pitolisant and sodium oxalate, so should be third line.
ACCEPTED pending
Action

5.4. Estradiol (Oestrogel) 0.06% ww pump pack 750mcg/actuation gel
Submitted by: Dr Hame Lata, Consultant Sexual & Reproductive Health & NHSH Menopause Specialist
Indication: Hormone replacement therapy (HRT) for oestrogen deficiency symptoms in perimenopausal & postmenopausal women and women with Premature Ovarian Insufficiency. Prevention of osteoporosis in postmenopausal women at high risk of future fractures who are intolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis.
Comments: This submission is coming into line with what is already happening in primary care. It is widening the choice of HRT preparations for women.
ACCEPTED

5.5. Liraglutide (Saxenda) 6mg/mL solution for injection in pre-filled pen (SMC2455)
Submitted by: Mairi Wotherspoon and Val MacDonald, Advanced Dietetic Practitioners
Indication: As an adjunct to a reduced-calorie diet and increased physical activity for weight management in adult patients with an initial Body Mass Index (BMI) of ≥30kg/m² (obese), or ≥27kg/m² to <30kg/m² (overweight) in the presence of at least one weight-related comorbidity such as dysglycaemia (prediabetes or type 2 diabetes mellitus), hypertension, dyslipidaemia or obstructive sleep apnoea.
SMC restriction:
BMI ≥35kg/m2* (obesity class II and above) with:

- Non-diabetic hyperglycaemia (prediabetes) at high risk of type 2 diabetes which is defined as having either: o Fasting plasma glucose level of 5.5 to 6.9mmol/L or o HbA1c of 6.0 to 6.4% (42 to 47mmol/mol), and
- High risk of cardiovascular disease (CVD): o Total cholesterol >5mmol/L, or o High-density lipoprotein (HDL) 140mmHg.

Patients should be treated in a specialist weight management service.
*a lower BMI cut-off may be more appropriate for members of minority ethnic groups known to be at equivalent risk of the consequences of obesity at a lower BMI than the white population.

Stephen McCabe gave an informative background talk.

Comments: The TAM Subgroup stated that the medication should be accepted on the grounds that 1) there is an evidence base for its use, as described by the SMC, 2) there is an unmet therapeutic need, as highlighted by Dr McCabe and 3) that there is a public and service expectation to be met and/or managed and there may be implications for NHS Highland should it be rejected. However there are concerns as to what impact this will have on the Specialist Weight Management Service and on Primary Care and it expressed the need for NHS Highland to act appropriately to meet the expectations of the patients, the service and the recommendations of SMC.

Liraglutide has been approved by SMC for weight management with very specific criteria including that patients are managed by a specialist weight management service. Concern was noted that there is likely to be great demand and that access to the service will be the rate limiting factor, which then could bring other pressures onto frontline services. Suggest that it be put to GP Subcommittee for comment on the practicalities prior to being approved due to a number of concerns:

- Capacity for the GPs to take on new chronic disease monitoring under the current environment, in which GPs are operating might not be possible.
- Clarification needed as to where the monitoring will be carried out, eg: ITR, Community treatment and care service (due to be rolled out this year) or whether GPs are involved.
- Impact on Community nurses to do injection training.

Clarified that responsibility for the prescribing, training in the use of liraglutide and therapeutic monitoring would be the responsibility of primary care but weight management monitoring would be done via the Specialist Weight Management Service, not primary care.
Agreed that both the formulary submission and its associated Healthy Weight guidance be submitted to the GP subcommittee for discussion prior to being accepted onto the Highland Formulary.
ACCEPTED pending
Action

5.6. Needles for pre-filled and reusable pen injectors

- BD Viva (Pack of 90) 4mm/32 gauge
- BD Mirco-Fine Ultra (Pack of 100) 4mm/32 gauge
- BD AutoShield Due (Pack of 100) 5mm/30 gauge

Submitted by: Dr David MacFarlane, Consultant Physician
Indication: For injecting insulin.
Comments: There is a wide variety of needles that are being prescribed, which means that we are not being cost effective as a health board. The diabetic team will consider different products and put to a patient user group to see which products patients would prefer. Cost effectiveness and patient acceptability is therefore taken into account for needle recommendations.
ACCEPTED

EXTRA ITEM DISCUSSED – FUNDING OF TAM

An aim of TAM is to improve the governance of the maintenance and development of guidance in NHS Highland. This is not able to be fully realised due to very limited staff support. There is a lot of guidance sitting on TAM that is out of date and getting through that alone is an administrative burden. Everyone is sitting in a very tight financial situation just now and it's very hard to get any additional money to fund TAM, but it is felt that we need to put a marker in the sand. There are a variety of opinions across the Board as to how useful TAM is to different staff groups. It would be worth individual Members of this group submitting their response to that. GP Subcommittee's opinion would be helpful.

Is there a small amount of resource that we could secure from within Highland, if people fully understood how important the guidance was to clinical practice, both in primary and secondary care?

What are the Clinical Governance Committee and the Board doing? Surely the availability of appropriate guidance is one of the fundamental aspects of patient safety for the whole organisation, which also provides advice about cost effective use of therapeutics.

Claire Copeland and Rob Cargill have been invited to attend a future Subgroup meeting.

Should those that are adverse to TAM be invited to attend ADTC to clarify why they don't think it is of use and needed within the organisation? A supporting letter to be sent from the Chair of this Subgroup stating the clinical reasons for TAM. It was strongly felt that this Group was very effective in making valid, evidence-based clinical decisions.

An SBAR to be written and given to both GP Subcommittee and Hospital Subcommittee to be taken forward to the Area Clinical Forum. A short confidential survey also to be developed for members of the Subgroup to complete.
Action

Duncan Scott left the meeting.

6. STOMA ACCESSORIES FORMULARY

ACCEPTED

7. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS

There have been several changes to the insulins that are on the Formulary. The Formulary insulin table has

been reviewed and updated and will be to the next Subgroup as quick-reference-guide. This has also been done for the inhalers which will also be submitted to the next Subgroup. Noted and approved.

- Dapoxetine monograph wording re SMC status – not discussed due to time constraints.
- Glucose monitoring – Glucose interstitial fluid detection sensor – not discussed due to time constraints.

8. SWITCH ASSESSMENT - MELATONIN

Melatonin has an appreciable spend in primary care prescribing. A cost-effective branded generic prescribing switch is proposed; from Pharmacy Nord brand to Ceyesto.

The switch should be automated with a message being put on Scriptswitch to inform patients. Two patient groups were described, paediatrics and care home residents. It was noted that there is often reluctance by parents and carers to change the preparation of something because they have a stable child that's sleeping well. Education about the change and what you are trying to achieve needs to made.

The current allocation of pharmacy time to general practice is the primary care improvement plan. That's a new GP contract pharmacy allocation, so most of the pharmacotherapy time where practices have any is supposed to be relieving GP workloads, meaning pharmacists in primary care would not be able to do this switch in the way that might have been done previously. This will be looked at on a practice by practice basis but was felt that cost effective use of medicines is part of the clinical process. Could community pharmacies take this on? Agreed they would be involved to support this to know what products they stock but it was not appropriate to request they initiate discussion with patients. The sleep pathway is being reviewed and it clarifies who is responsible for what. This will be submitted to a future meeting for discussion.

Melatonin is in the Formulary for children but there is also prescribing within adults. A request to develop a guideline for adults has been raised with New Craigs and for Care Home residents with the Care of the Elderly Consultant, Martin Wilson.

ACCEPTED

9. FORMULARY REPORT

Noted.

10. SMC ADVICE

Noted.

11. NEW TAM GUIDANCE FOR APPROVAL

11.1. ECG monitoring of patient on drugs known to prolong the QT interval

- Credible Meds is an American site that is used in practice, but you do have to register to use it? Feedback from Subgroup is that it is free and easy to register and once registered logging on is easy. It is regularly used by ward pharmacists and UKMI (UK Medicines Information service) endorse its use, therefore happy with the inclusion of Credible Meds in the guidance.
- ECG requirements need to be questioned as three in the space of two weeks seems to be a lot and who is going to accommodate them? Have Cardiology spoken to the ITR service about this? If not, where are the ECGs being done?

ACCEPTED pending

Action

11.2. Palpable cervical lymph nodes

- Quite wordy guidance but the risk table is very helpful.

ACCEPTED

11.3. Gender Identity guidance

- This is interim guidance until National Gender Recognition guidance is released.
- The information for primary care is a link to a large document, could a quick reference guide be developed? Explained that this may not be feasible as this is interim guidance while awaiting the imminent release of the national Gender Recognition Protocol.
- Therefore requested if these patients can be referred to the clinic and the clinic then inform the GP if there are any specific tests, etc, that need to be carried out while the patient is on the waiting list.

ACCEPTED pending

Action

11.4. Major haemorrhage protocol (Raigmore)

- Include no specific 'licensed' antagonist yet for edoxaban.

ACCEPTED pending

Action

11.5. Guidance for Prescribing Medication Assisted Treatment (MAT) in NHS Highland

- There are a number of anomalies as the drugs in this particular guidance and in the buprenorphine guidance (item 11.6) don't actually match the formulary choices, so this is a piece of work that will need to be done.
- Really, useful, educational document but it is very long. Readability will be improved by click down menus on TAM.
- OST abbreviation to be put in full in the first instance.
- Could a quick reference summary be developed to include who is responsible for what?

ACCEPTED

Action

11.6. Guidance For The Use Of Oral Buprenorphine Products For The Treatment Of Opioid Dependence In NHS Highland

- There are a number of anomalies as the drugs listed in the guidance don't match the formulary choices, so this is a piece of work that will need to be done.
- Could a quick reference summary be developed to include who is responsible for what?
- Oral buprenorphine guidance has Grampian in the content page, needs updating to Highland.

ACCEPTED

Action

11.7. Post-operative opioids

- Remove individual clinician's name and just have the Chronic Pain Service.
- The post-operative opioids patient information is all about non opioid drugs, should this be included?
- Reword introduction as unsure if figures quoted are correct.

ACCEPTED pending

Action

11.8. Administration of vancomycin to patients receiving haemodiafiltration

- This is a specialised piece of guidance that will only be used by the Renal Unit.
- Table 3 has no units, should have mg/L.

ACCEPTED

Action

11.9. Venous thromboembolism (VTE) prophylaxis: New Craigs

For noting only – ratified via email prior to Subgroup.

12. GUIDELINE UPDATES

12.1. Antimicrobial – Neutropenic sepsis

ACCEPTED

12.2. Chronic pain pathway

- Can we highlight to the Director of Pharmacy that there is no allocated Pharmacy input into the Chronic Pain Team?
- Previously, the agreement with GP Subcommittee and the Chronic Pain Team is that the route to the chronic pain team was only through GP referral. Consultants couldn't directly refer; 1) the GPs are better placed to know whether the patient is likely to benefit from the Chronic Pain Team and 2) it avoids the Chronic Pain Team becoming inundated with referrals, which would have waiting list implications. Request to review/discuss the referral process with the Chronic Pain Team.

ACCEPTED pending

Action

12.3. Hyperkalaemia

ACCEPTED

12.4.Healthy Weight (adults)

- NHS Western Isles led on this last January and this guidance follows a 12-month period for the medication to be prescribed. The question is then what happens to those patients after the 12 months? Should there be mention of retreatment?
- To go to GP Subcommittee for comment and then resubmitted to a future meeting.

PENDING

Action

Liam Callaghan left the meeting.

12.5.Smoking cessation

- Should vaping be included?
- Quite a proscriptive guideline.

ACCEPTED pending

Action

Claire Wright left the meeting.

13. GUIDELINE MINOR AMENDMENTS

Noted and approved.

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

Strabismus amblyopia
Cataract
Glaucoma
Slit Lamp
Dry eye syndrome
Belpharitis
Conjunctivitis
UTI diagnosis unclear infection source likely respiratory or urinary tract
Amikacin
Cellulitis/wound infections
Spirometry

15. GUIDELINE DELETIONS

Long term ventilation: Primary Care: COVID-19 *(COVID-19 guidance review: guidance no longer required or assimilated into standard guidance)*.

Rob Peel left the meeting – meeting no longer quorate but no further decisions made.

16. TAM REPORT

A brief update was provided.

17. ENVIRONMENT

- The medical director has agreed that focus will be on polypharmacy and pharmaceutical waste and there is a project with Ullapool Medical Practice to look at pharmaceutical waste in particular.
- The Medicines Research Council is still ongoing looking at the eco-directed Formulary and this could impact on Formulary decision making.
- A big review has been done regarding inhalers. Also looking at disposal of inhalers, there is no recycling scheme available in Scotland, so trying to do a big drive to encourage patients to return them to community pharmacies for disposal.
- There is a pen-cycle, injectable pen recycling scheme throughout the UK and work is underway to look at how best this can be supported in NHS Highland.
- Blister pack recycling schemes are provided by some pharmaceutical companies, further investigation to be made regarding if this could be made available for NHS Highland.

18. NHS WESTERN ISLES

Nothing to report.

19. ANY OTHER COMPETENT BUSINESS

Very Low Calorie Diet
A pilot project and being carried out in Highland and it was hoped that a report would be made to a future Subgroup.

Processing NCMAG advice
The National Medicines Advisory Group are now publishing guidance and are a national group that make pragmatic recommendations on cancer guidance. To incorporate this within NHS Highland processes, PH to liaise with the Oncology Team, suggest present information the same way that SMC advice is reported.

20. DATE OF NEXT MEETING

Next meeting to take place on Thursday 29 June, 14:00-16:00 via TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Solriamfetol (Sunosi) 75mg and 150mg film-coated tablets (SMC2439) *Back to minutes*	April 2023	Clarify place in therapy.	**PH**
Liraglutide (Saxenda) 6mg/mL solution for injection in pre-filled pen (SMC2455) *Back to minutes*	April 2023	To be put to GP Subcommittee for comment on the practicalities prior to being approved due to a number of concerns.	**PH**
Funding of TAM *Back to minutes*	April 2023	• A supporting letter to be sent from the Chair of this Subgroup stating the clinical reasons for TAM. It was strongly felt that this Group was very effective in making valid, evidence-based clinical decisions. • An SBAR to be written and given to both GP Subcommittee and Hospital Subcommittee to be taken forward to the Area Clinical Forum. • A short confidential survey also to be developed for members of the Subgroup to complete.	**PH/AL/DS**
ECG monitoring of patient on drugs known to prolong the QT interval *Back to minutes*	April 2023	ECG requirements need to be questioned as three in the space of two weeks seems to be a lot and who is going to accommodate them? Have Cardiology spoken to the ITR service about this? If not where are the ECGs being done?	**PH**
Gender Identity guidance *Back to minutes*	April 2023	Could a quick reference guide be developed for primary care?	**PH**
Major haemorrhage protocol (Raigmore) *Back to minutes*	April 2023	Include no specific licensed antagonist yet for edoxaban.	**PH**
Guidance for Prescribing Medication Assisted Treatment (MAT) in NHS Highland *Back to minutes*	April 2023	• There are a number of anomalies as the drugs in this particular guidance and in the buprenorphine guidance (item 11.6) don't actually match the formulary choices, so this is a piece of work that will need to be done. • OST abbreviation to be put in full in the first instance. • Could a quick reference summary be developed to include who is responsible for what?	**PH**
Guidance For The Use Of Oral Buprenorphine Products For The Treatment Of Opioid	April 2023	• There are a number of anomalies as the drugs don't match the formulary choices, so this is a piece of work that will need to be	**PH**

Dependence In NHS Highland *Back to minutes*		done. • Could a quick reference summary be developed to include who is responsible for what? • Oral buprenorphine guidance has Grampian in the content page, needs updating to Highland.	
Post-operative opioids *Back to minutes*	April 2023	• Remove individual clinician's name and just have the Chronic Pain Service. • The post-operative opioids patient information is all about non opioid drugs, should this be included? • Reword introduction as unsure if figures quoted are correct.	**PH**
Administration of vancomycin to patients receiving haemodiafiltration *Back to minutes*	April 2023	Table 3 has no units, should have mg/L.	**PH**
Chronic pain pathway *Back to minutes*	April 2023	• Can we highlight to the Director of Pharmacy that there is no allocated Pharmacy input into the Chronic Pain Team? • Request to review/discuss the referral process with the Chronic Pain Team.	**PH**
Healthy Weight (adults) *Back to minutes*	April 2023	• What happens to patients after the 12 months? There is mention about retreatment. • To go to GP Subcommittee for comment and then resubmitted to a future meeting.	**PH**
Smoking cessation *Back to minutes*	April 2023	Should vaping be included?	**PH**