TAM SUBGROUP OF THE NHS HIGHLAND AREA DRUG AND THERAPEUTICS COMMITTEE

Pharmacy Services
Assynt House
Inverness
Tel: 01463 706806
www.nhshighland.scot.nhs.uk/

DRAFT MINUTE of meeting of the TAM Subgroup of NHS Highland ADTC
29 June 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 Mairi Dunbar, Lead Pharmacist Paediatrics, Obstetrics and Gynaecology Damon Horn, HEPMA Pharmacist Liam Callaghan, Chief Pharmacist, Western Isles Hospital Joanne McCoy, MySelf-Management Manager Linda Burgin, Patient Representative Dr Simon Thompson, Consultant Physician Jenny Munro, AP Physiotherapist Continence and Independent Prescriber
In attendance:	Wendy Anderson, Formulary Assistant Donna Fraser, TAM Project Support Manager Rob Cargill, Deputy Medical Director Fiona Macfarlane, Associate Director of Pharmacy (Community Pharmacy) & CD Governance Joanne Ryrie, Primary Care Clinical Pharmacist (East Ross) Claire Henderson-Hughes, Medicines Management Nurse
Apologies:	Dr Antonia Reed, GP (comments submitted)

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

No register of interests were declared.

3. MINUTES OF MEETING HELD ON 27 April 2023

Minutes accepted as accurate.

4. ACTIONS FROM PREVIOUS MEETING

A brief verbal report was provided and the letter response from the Director of Pharmacy read regarding the lack of pharmacy input to the chronic pain service.

Noted that it was very disappointing that there was no pharmacy input to the chronic pain service. This needs to be handled carefully, because the pharmacotherapy service is to relieve GP workload, not to prop up other services, such as the Chronic Pain Team. If a teach and train model is proposed, then this would need to be discussed at GP Subcommittee. Noted that, rather than looking at cost-saving, a clinical model should be followed. Also noted that the Chronic Pain Team should be a full multidisciplinary service, as well as needing to include pharmacy. This is to be fed back to the chronic pain service.

MySelf-Management work closely with the Pain Management Team, who have been developing a new

strategy and are setting up a new patient and 3rd sector network.

5. FOLLOW UP REPORT

A brief verbal report was provided.

6. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

6.1. Haematology Chemotherapy formulary submissions

All accepted.

Drug (name, form, strength and manufacturer)	SMC number & status
Polatuzumab vedotin (Polivy) 140mg in 20mL powder for solution for infusion. Roche Products Limited.	SMC2525 – accepted (restricted use) SMC2524 – accepted (with PAS) – confidential not published until 10 July 2023
Azacitidine (Onureg) tablets, 200mg & 300mg. Bristol-Myers Squibb Pharmaceuticals Limited	SMC2533 – accepted (with PAS) – confidential not published until 10 July 2023

6.2. Oncology Chemotherapy formulary submissions

All accepted.

Noted that a patient was prescribed pembrolizumab as per SMC2538 on Tuesday this week prior to ratification but with the knowledge that a request to be added to the formulary had been made.

Drug (name, form, strength and manufacturer)	SMC number & status
Trastuzumab deruxtecan 100mg powder for concentrate for solution for infusion (Enhertu) Daiichi Sankyo UK Ltd	SMC2545 10/03/23 – full submission assessed under the end of life and orphan equivalent medicine process. Accepted for restricted use.
Nivolumab 10mg/ml concentrate for solution for infusion (Opdivo) Bristol Myers Squibb	SMC2519 05/05/23 – full submission assessed under the end of life and orphan equivalent medicine process. Accepted for use.
Pembrolizumab concentrate for solution for infusion (Keytruda) Merck Sharp & Dohme (UK) Limited	SMC2538 05/05/23 – full submission. Accepted for use.
Pembrolizumab concentrate for solution for infusion (Keytruda) Merck Sharp & Dohme (UK) Ltd	SMC2526 10/03/23 – full submission. Accepted for use.

6.3. Relugolix (Ryeqo) 40mg, estradiol 1mg, norethisterone acetate 0.5mg film-coated tablets (SMC2442)

Submitted by: Mairi Dunbar, Lead Paediatric Pharmacist

Indication: Treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age. SMC restriction: for use in patients who have failed or are unsuitable for conventional therapies (first line treatments), such as tranexamic acid, hormonal contraceptives and intrauterine delivery systems.

Comments: This is an oral treatment so it removes the need for attending GP practices for an injection.

ACCEPTED

6.4. Inclisiran (Leqvio) 284mg solution for injection in pre-filled syringe (SMC2358)

Submitted by: Rosemary Clarke, Consultant Medical Biochemist

Indication: For adults with primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet: in combination with a statin or statin with other lipid lowering therapies in patients who are unable to reach LDL-C goals with the maximum tolerated dose of a statin, or alone or in combination with other lipid lowering therapies in patients who are statin intolerant, or for whom a statin is contraindicated. SMC restriction: for specialist use only in patients at high cardiovascular risk as follows: patients with heterozygous familial hypercholesterolaemia (HeFH) and LDL-C ≥5.0mmol/L, for primary prevention of cardiovascular events or, patients with HeFH and LDL-C≥3.5mmol/L, for secondary prevention of cardiovascular events or, patients with high risk due to previous cardiovascular events and LDL-C≥4.0mmol/L or, patients with recurrent/polyvascular disease and LDL-C≥3.5mmol/L.

Comments: Small patient group under specialist use only via the lipid clinic. Homecare company have agreed to collect used packaging & used products and recycle where possible. **ACCEPTED**

6.5. Tralokinumab (Adtralza)150mg solution for injection in pre-filled syringe (SMC2403)

Submitted by: Dr Keith Woo, Consultant Dermatologist

Indication: Atopic dermatitis.
Comments: Will be used in a very limited number of patients and there are good stopping criteria.
ACCEPTED

6.6. Upadacitinib (Rinvoq®) 15mg, 30mg, 45mg prolonged release tablets (SMC2575)
Submitted by: Dr Neil Jamieson, Consultant Gastroenterologist
Indication: For the treatment of adult patients with moderately to severely active Crohn's disease (CD) who have had an inadequate response, lost response or were intolerant to either conventional therapy or a biologic agent, or for whom such therapies are not advisable.
Comments: Small numbers of patients and it provides another treatment option. Will have very minimal budget impact and could be cost saving.
ACCEPTED

6.7. Glucose liquid 60ml (contains 15g of glucose in one shot) Lift Glucose Juice Shot (previously known as Glucojuice)
Submitted by: Dr Victoria Franklin, Consultant Paediatrician, Lead Paediatrician for Diabetes Service
Indication: Treatment of hypoglycaemia.
Comments: This is following national guidance and it has already been added to the Formulary due to time issues. The main reason for using this is to prevent teeth decay because the liquid can be used with a straw, so avoiding contact with teeth for children who will have to use sugary products on a fairly frequent basis. Request a Pink One article.
ACCEPTED
Action

6.8. Sucralfate (Antepsin®) 1g in 5ml suspension
Submitted by: Colin Richards, Consultant, Colorectal Unit
Indication: Severe radiation proctitis.
Comments: Off-licence use of licensed medicine; to be used as an enema. Have the community nursing team been consulted? Have all teams been trained on how to administer it? Note that enemas cannot be administered at GP practices. Noted that 60mL luer-lock syringes are not routinely available in GP practices. They would require to be ordered and may cause a delay. Community nursing teams often hold items like this and, as they also have prescribers, could take on the prescribing as well as the demonstration on how to do it. Can we maintain supply of catheters for this? How is this going to be implemented? Suggest that a message on the GP prescribing system be added to state, eg: 'When prescribed for radiation proctitis, you need: and provide a list of what is required'. Consider that where this formulation is unable to be administered in this way that an alternative is given, such as the unlicensed enema.
It was agreed that many of the issues relate to the supply and administration of the medicine and not the medicine itself, therefore agreed to be added to the formulary and the process issues to be addressed within the radiation proctitis guidance.
ACCEPTED
Action

6.9. Alfentanil nasal spray 140 microgram/spray
Submitted by: Lucy Dixon, Macmillan Palliative Care Community Pharmacist
Indication: Pain often related to a particular event (for example movement, dressing changes); sudden in onset, can be severe, but may not last long.
Comments: Unlicensed - Schedule 2 Controlled Drug. This is specialist recommendation only. Place in therapy to be clearly stated to avoid being prescribed as first line. Request a guideline about how to manage incident pain in palliative care (different to breakthrough pain). Control of initiation is key, so use should be monitored.
ACCEPTED pending
Action

7. Formulary review

7.1. Blood-related products
ACCEPTED

7.2. Pharmacy First formulary
Noted.

8. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS

Noted and approved. A Scriptswitch note to be added to Gluco RX needles to recommend an alternative.

- ***Wound Formulary (product list update)***
  Noted and approved. Thanks made to those involved with the update.
- ***Gluten Free Formulary***
  Noted.

9. FORMULARY REPORT AND ADTC UPDATE

There is a supply issue with Peptac at the moment and Gaviscon Advance has been recommended as a replacement by National Procurement. This however is a different dose and more expensive. National Procurement to be contacted to ask if the implications for primary care have been considered. If there is a shortage of Peptac in the community, it can be managed with other alginate products, which also don't involve changing the dose. A letter to be written to National Procurement.
Action

National Cancer Medicines Advisory Group (NCMAG) was discussed at ADTC. Pragmatic advice is provided regarding cancer treatment. Advice in a layout similar to SMC will be provided to Oncology and Haematology and they will inform as to which treatments they would like to be ratified by this Subgroup.

10. SMC ADVICE

Noted.

11. NEW TAM GUIDANCE FOR APPROVAL

11.1. Paracetamol overdose

ACCEPTED

11.2. Gall bladder polyp surveillance

- No input has been sought from primary care.
- Request that, when the report is delivered by radiology, the time of a review scan is specified.

ACCEPTED
Action

11.3. Primary hip and knee arthroplasty post-operative ERAS bundle

This is a test piece of guidance to the Subgroup. HEPMA has the facility to create order sets, groups of medicines to be prescribed for the majority of patients in a particular situation. For the HEPMA CAG (Change Agreement Group) to agree to an order set being created, they need to know that there is guidance in existence that can be referred to.

It was agreed that order sets would be governed by the HEPMA CAG group. Where order sets lead to identifying a gap in guidance, then the guidance itself would come to TAM Subgroup.

- This guidance is an interim measure. It will take time for an order set to be created on HEPMA, having this protocol available on TAM in the meantime, informs the clinician of the standard medicines to be prescribed. It is noted that fuller arthroplasty guidance may be needed.
- Lansoprazole is first line PPI in the formulary. To query why this is not reflected in this guidance.
- Why is dose of omeprazole 40mg?

ACCEPTED pending
Action

11.4. Colorectal

It is not clear what consultation took place with primary care. Primary care involvement should be explicitly explained. Submission form to be amended to direct people to the correct process, eg: for primary care representation contact Associate Medical Director: Claire Copeland, or contact the GP subcommittee.

Primary care management of anal fissures

- Guidance is very useful.

ACCEPTED

Management of haemorrhoidal disease in General Practice

- What is the dissemination process? Pink One Article to be written and Claire Copeland to be contacted to include in the weekly GP bulletin.
- Not adequate to state ‘not to excessively strain at the toilet’ JM to liaise with author on wording.

ACCEPTED pending

Management of radiation proctitis

- To be submitted to GP Subcommittee as it is unclear who is to deliver this and by what means. See comments raised under item 6.8

REJECTED

Primary care management of pilonidal disease

- This will go to AMT for antimicrobial treatment options to be added and will come back as a minor amendment.
- The flowchart is useful as stand-alone guidance without the information written in prose. However this can be kept.

ACCEPTED

Primary care management of pruritus ani

- Information needs to be reviewed and brought up to date to include referral for products and services. JM to liaise with author.
- To be resubmitted to August meeting.

REJECTED

Sucralfate enemas patient information leaflet

Noted

Action

11.5. Antimicrobial – Urinary Tract Infection

- Does extra information need to be added regarding QT prolongation and fluconazole acknowledging that it is a 14-day course? PH to liaise with ST.

ACCEPTED

Action

11.6. Antimicrobial – Skin/soft tissue infection (SSTI) affecting upper or lower limb or face (erysipelas) clinical pathway

- A number of errors in the flowchart were identified and clarification needed regarding responsibilities and availabilities within and out of hours.
- Western Isles have a similar workable document. This document to be shared with Western Isles for advice on how to present the information better.
- Primary care representation to be included.

REJECTED

Action

12. GUIDELINE UPDATES

12.1. Highest Risk list: COVID-19

At present this guidance does not have an author. Felt that Health Protection should be contacted regarding this. DS to be copied in to email.

ACCEPTED

Action

12.2. Hypertension management

This is a complete revision of the hypertension guidelines. The flow charts have been taken from national guidance and there is a lot more information involved in the guideline

- There will be some pharmacists who are running hypertension clinics, but the subdivision of normal blood pressure into different categories with recommendations for different interval measuring is a significant use of primary care resource that is not funded. There is no government funding in Scotland for well person checks at intervals.
- To be submitted to GP Subgroup with reference to resource and time implications.

REJECTED

Action

13. GUIDELINE MINOR AMENDMENTS

Noted and approved.

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

None to note.

Jude Watmough left the meeting.

15. TAM REPORT

A brief update was provided.

DVT and warfarin guidance being significantly out of date were of particular concern and is to be escalated to the author for review.

TAM are moving to the Right Decision for Health and Care. Some premigration testing on the site has been undertaken and there have been a few issues which have either been resolved or are in the process of being resolved. The live migration to RDS is imminent. The timeline is three weeks to go through every single page of the migrated content to check that it is accurate. With a tight timescale due to staffing to deal with any particular issues prior to next Subgroup. The decision to state TAM can go live on the migrated content will be made at the next meeting. The contract with Tactuum runs out at the end of September for the current software, this means that there will be one month where both applications are running, after which the old content will be removed. If anybody accesses the old system, they will be automatically transferred to the new site.

16. ENVIRONMENT

Currently involved in pharmaceutical waste and the Formulary is at the centre of that Medicines Research Council project.

At a recent pharamaceutical waste meeting a request was raised that 'no drug options' be made available. The current formulary isn't set up to be able to achieve this as it is a list of drugs not conditions. As the Formulary is moving to the right decision service it might be possible to revamp the Formulary using the DM&D structure with a database to support the system If anybody has any thoughts or any ideas or knows of any tools that can be used could this be shared?

17. NHS WESTERN ISLES

LC declared this would be his last meeting and that Sue Price would be taking over. He was thanked for his involvement over the years.

18. ANY OTHER COMPETENT BUSINESS

Review of terms of reference and subgroup membership

Agreed that three issues of note to be discussed between subgroups by a few Subgroup members:

- Adding HEPMA order sets as an exclusion to TAM processes.
- Clarifying finance as to what happens with drug spends that are incurred.
- Lay representation on TAM Subgroup.

Action

19. DATE OF NEXT MEETING

Next meeting to take place on Thursday 31 August, 14:00-16:00 via TEAMS.

Proposed dates for 2024 were agreed as follows:
Thursday 29 February
Thursday 25 April
Thursday 27 June
Thursday 29 August
Thursday 31 October
Thursday 5 December.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Glucose liquid 60mL (contains 15g of glucose in one shot) Lift Glucose Juice Shot (previously	June 2023	Request a Pink One article.	**PH**

known as Glucojuice) *Back to minutes*			
Sucralfate (Antepsin®) 1g in 5mL suspension *Back to minutes*	June 2023	• Have the community nursing team been consulted? • Have all teams been trained on how to administer it? • Can we maintain supply? • How is this going to be implemented? • To clarify monograph re alternative preparation if this formulation is not suitable	**PH**
Alfentanil nasal spray 140 microgram/spray *Back to minutes*	June 2023	• Place in therapy required to avoid being prescribed as first line. • Request a guideline about how to manage incident pain in palliative care which would be different to breakthrough pain.	**PH**
Gall bladder polyp surveillance *Back to minutes*	June 2023	• No input has been sought from primary care. • Request that when the report is delivered in radiology that the time of a review scan is specified.	**PH**
Primary hip and knee arthroplasty post-operative ERAS bundle *Back to minutes*	June 2023	• Lansoprazole is first line in the Highland Formulary and should be reflected in this guidance. • Why is dose of omeprazole 40mg?	**PH**
Colorectal - general *Back to minutes*	June 2023	What consultation took place with primary care? Primary care involvement should be explicitly explained. Submission form to be amended to direct people to the correct process.	**PH**
Colorectal - Management of haemorrhoidal disease in General Practice *Back to minutes*	June 2023	• Pink One article • GP weekly bulletin • JM to liaise with author on wording	**PH**
Colorectal - Management of radiation proctitis *Back to minutes*	June 2023	• To be submitted to GP Subcommittee as it is unclear who delivers it and by what means.	**PH**
Colorectal - Primary care management of pruritus ani *Back to minutes*	June 2023	• Information needs to be reviewed and brought up to date. JM to liaise with author.	**JM**
Antimicrobial – Urinary Tract Infection *Back to minutes*	June 2023	Confirm what information needs to be added regarding QT prolongation and 14-day treatment of fluconazole.	**PH/ST**
Antimicrobial – Skin/soft tissue infection (SSTI) affecting upper or lower limb or face (erysipelas) clinical pathway *Back to minutes*	June 2023	Initial management (big green box), OPAT inclusion criteria. It should say discuss with onsite medical staff then contact ID team in hours direct via switchboard or microbiology out of hours via Raigmore switchboard if:. Flow chart is confusing: • Column 1 (blue boxes), says check for cation interactions, assume should say medication? • Middle column: OPAT inclusion and exclusion criteria are the same, especially animal/human bites and drug users. • Is there a difference between AKI and eGFR under 30 in terms of referral and why the distinction? It currently reads that they must have a eGFR under 30 to be referred • What if GP doesn't have up to date bloods? • Timing of referral to OPAT in hours and out	**PH**

		of hours; experience of Raigmore in hours means 9 to 5 whereas GP is 8 to 6. • What sort of time response is the patient going to expect, especially from an OOH email? • Who is prescribing the drugs for OPAT? • Who is giving the ceftriaxone or daptomycin? • Who is responsible until OPAT picks up? • How will GP know OPAT is doing anything? • To be shared with Western Isles as an example of how to present information and see if they can improve the information. • Primary care representation to be included.	
Highest Risk list: COVID-19 *Back to minutes*	June 2023	Contact Health Protection re author/lead reviewer.	**PH/DS**
Hypertension management *Back to minutes*	June 2023	To be submitted to GP Subgroup.	**PH**
AOCB – Review of terms of reference and subgroup membership *Back to minutes*	June 2023	Three issues of note to be discussed between subgroups by a few Subgroup members: • Adding HEPMA order sets as an exclusion to TAM processes. • Clarifying finance as to what happens with drug spends are incurred. • Lay representation on TAM Subgroup.	**PH**