TAM SUBGROUP OF THE NHS HIGHLAND AREA DRUG AND THERAPEUTICS COMMITTEE

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

MINUTE of meeting of the TAM Subgroup of NHS Highland ADTC
27 October 2022, 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 Jenny Munro, AP Physiotherapist, Continence and Independent Prescriber Damon Horn, HEPMA Pharmacist Joanne McCoy, LGOWIT Manager Dr Antonia Reed, GP Dr Robert Peel, Consultant Nephrologist Jane Wylie, Lead Pharmacist, Surgery and Anaesthetics Liam Callaghan, Chief Pharmacist, NHS Western Isles
In attendance:	Wendy Anderson, Formulary Assistant Donna Fraser, TAM Project Support Manager Elaine Farrell, Advanced Practitioner Tissue Viability (item 7) Nancy Mackay, Tissue Viability Development Post (item 7) Amy Macaskill, Consultant Psychiatrist (item 10.7) Fiona Turnbull, Librarian Katy Connelly, Foundation Year Trainee Pharmacist Lauren Beattie, Foundation Year Trainee Pharmacist
Apologies:	Dr Alan Miles, GP Louise Reid, Acute Pain Nurse Lead/Claire Wright, Acute Pain Nurse Linda Burgin, Patient Representative

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

No interests were declared.

3. MINUTES OF MEETING HELD ON 25 AUGUST 2022

Accepted as accurate.

4. FOLLOW UP REPORT

A couple of items had been progressed and a brief verbal update was given with particular note made that the Pink One had been published and distributed.

5. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

5.1. Upadacitinib (Rinvoq); 15mg and 30mg prolonged-release tablets (SMC2417)
Submitted by: Dr Louise Macfarlane, Consultant Dermatologist
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: The cost effectiveness is dependent upon the dosage regimen that you use eg if you are on 30mg, you need to use a 30mg tablet, you don't use 2 x 15mg tablets that is an important point and should be noted in the Formulary. The cost effectiveness is also dependent variable against what it has been

compared to. The clinical use of upadacitinib is not expected to be a risk for the environment.
ACCEPTED

5.2. Upadacitinib (Rinvoq) 15mg, 30mg, and 45mg prolonged-release tablets (SMC2510)
Submitted by: Neil Jamieson, Consultant Gastroenterologist
Indication: For the treatment of adult patients with moderately to severely active ulcerative colitis who have had an inadequate response, lost response or were intolerant to either conventional therapy or a biologic agent.
Comments: Cost saving or pressure, depending on dose. The clinical use of upadacitinib is not expected to be a risk for the environment. Request clarification of place in therapy.
ACCEPTED pending
Action
Duncan Scott joined the meeting.

5.3. Filgotinib (Jyseleca) 200mg film coated tablets (SMC2467)
Submitted by: Neil Jamieson, Consultant Gastroenterologist
Indication: For the treatment of adult patients with moderately to severely active ulcerative colitis (UC) who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a biologic agent.
Comments: Cost saving. Provides an alternative oral treatment. No environmental effects are expected following clinical use. As above, request clarification of place in therapy.
ACCEPTED pending
Action
Liam Callaghan joined the meeting.

5.4. Dapagliflozin (Forxiga) 10mg film-coated tablets (SMC2428)
Submitted by: Joanna Garrod, Area Renal Pharmacist
Indication: In adults for the treatment of chronic kidney disease.
Comments: Predicted to present an insignificant risk to the environment. Place in therapy to be included in current CKD guidance that sits on TAM. Request that a quick reference guide is developed from the current National guidelines. Have the diabetes team been consulted as the guidelines as they suggest to refer patients to them? Prior to this submission feedback received from the Diabetes Team was that they do not want it used in type 1 diabetics. There is a patient information leaflet, check to see if this would be of use. Specialist initiation or recommendation only would be preferred.
ACCEPTED pending
Action

6. FORMULARY MINOR ADDITIONS/DELETIONS AMENDMENTS

Noted and approved.

7. WOUND FORMULARY

Elaine Farrell, Advanced Practitioner Tissue Viability and Nancy Mackay, Tissue Viability Development Post provided a presentation on this vast piece of work which included background information and stating that it had been developed on a national level with multi-disciplinary representation.
The wound guidelines and formulary cover all NHS Highland, bringing HHSCP and A&BHSCP in alignment and enables wider access to the formulary and guidelines for relevant staff, will promote good and cost-effective wound management and support the small Tissue Viability team in upskilling the workforce in wound management.
NHS Western Isles has also worked on its wound formulary. Agreed that NHS Highland and NHS Western Isles wound management teams should liaise on their respective pieces of work to see if there is benefit in aligning the guidance and formulary across the Health Boards.

8. FORMULARY REPORT

Noted. The top non formulary drugs are being chased up with the relevant departments to see if they can be brought either as a submission to the Formulary to be added or that a recommendation can be made more widely that they should not be prescribed. Three of particular note were melatonin, alimemazine and famotidine.

9. SMC ADVICE

Noted.

10. NEW TAM GUIDANCE FOR APPROVAL

10.1. Emergency admission of adults with acute constipation

ACCEPTED

10.2. Hyperemesis

Outpatient and Inpatient Management of Hyperemesis Gravidarum
Hyperemesis algorithm
Hyperemesis assessment and discharge form (for information only)

- The information relevant to outpatients is right at the very end and hard to find. It would read better to change the order to outpatient management, primary care management, criteria for admission and then inpatient management.
- Prochlorperazine, promethazine and chlorpromazine, are all phenothiazines so format of bullet points needs to be changed as currently unclear.
- Domperidone is mentioned but safety has not been demonstrated for its use. Need to be clear where there is or there is not a risk associated with domperidone.
- In the flow chart ondansetron is not mentioned but it is in the guidance.
- Use of two drugs at once (if one is not working, you don't stop it and start another one, you add another one) is in the guidance but is not in the flow chart.
- Lack of information on Pabrinex dosing or how to use it. Should the refeeding protocols be used? Thromboprophylaxis is unclear; assuming it is for inpatients only but clarification required.
- In the flow chart highlight the two different classes and if they are using a 1st or 2nd line option.
- IV ranitidine is mentioned and it is not available.
- Clarify who is to get folic acid.

REJECTED

Action

10.3. Hyperosmolar Hyperglycaemic State (HHS) in adults

- On page 2, specify that if you run the bag of potassium at the same rate as detailed on the first page patient requires ECG monitoring and central line access.
- Dose information required for enoxaparin in the first hour.
- The first box needs to be reformatted.

ACCEPTED pending

Action

10.4. Groin hernia pathway

- Amend to 'referral for ultrasound will not be accepted' to improve clarity.

ACCEPTED pending

Action

Duncan Scott left the meeting.

10.5. Gallstone disease

ACCEPTED

10.6. Anti-reflux surgery

ACCEPTED

10.7. Attention deficit hyperactivity disorder

Dr Amy Macaskill provided some background information. There has been an exponential increase in referrals for ADHD across Scotland. NHS Highland was picked as a pilot site to work alongside the National Autism Implementation Team to develop a service. This guidance has been developed to be very clear about what the standard pathway for these referrals is. There is national guidance about private diagnosis and as there has been such an increase in the number of referrals, with some coming from private clinics or private practitioners who have set up across Scotland and across Britain, information has been included to recognise private diagnosis. Very clear guidance for the Royal College of Psychiatrists and NAIT is available to help ensure that private diagnosis, with suitable evidence being provided, are accepted without having to put patients through a lengthy further assessment.

The following was noted and agreed:

- It is useful and helpful guidance.
- More information to be provided regarding Medication indicated within the pathway.

- The NICE guidance refers to shared care protocols. Clarity about how the prescription and monitoring is working would be useful. Also useful to have some guidance on how and when it might be appropriate to take on a private initiated prescription.
- There is a lot of information in the FAQs which would sit better as a guideline.
- The guidance from the Royal College of Psychiatrists and from NAIT to be shared.
- Should this Group recommend to ADTC that NHS Highland look to writing a policy to provide advice for prescribers and other clinicians on private healthcare prescribing?
- Is it possible to have a list of approved private healthcare organisations? Question to be put to ADTC.
- National guidance on the split between private and NHS prescriptions to be taken forward through ADTC and see that CAG has an oversight on it.

ACCEPTED pending

Action

11. GUIDELINE UPDATES

11.1.Adult oral analgesia

- To be resubmitted due to a number of questions regarding the guidance.

REJECTED

Action

11.2.Teicoplanin

- Include under monitoring what tube they send it in.

ACCEPTED pending

Action

11.3.Gentamicin dosing in infective endocarditis

Removed and replaced by: move to using European Cardiology Society guidance published in 2015 and American Heart Association Guidance 2015.

ACCEPTED

11.4.Adults with asthma

Local guidance being removed and being replaced with a national document, which is the Precision Severe Asthma pathway. This is a drug company supported document with an appendix, for information only, explaining their Terms of Reference.

- The document states: 'This material has not been developed for patient use and should not be shared with patients'. Is it appropriate to put on TAM? Agreed it could be hosted on the Intranet with only a link being put on TAM.
- Another statement in the document reads 'the material is not intended to amount to advisable advice on which you should rely' therefore how useful is the document?
- Hard to read, with a lot of acronyms.
- When it says criteria to identify patients at risk, does that mean that we' are we supposed to go out and actively do that? It was noted that there is at least one project looking at patients who are on excess salbutamol inhalers, should the project or the guidance come first?
- These items are mentioned in the poster are they available in NHS Highland: Do we have a severe asthma clinic in NHS Highland? Do we have access to a pre-clinic test in secondary care? Is this guidance relevant locally? Would it be more appropriate to put in Highland if you are going to refer to our clinic, could you do these blood tests and a sputum culture? And then refer them?
- Recommend that this company supported document is rewritten to be more NHS Highland appropriate.

REJECTED

Action

12. GUIDELINE MINOR AMENDMENTS

Noted and approved.

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

Noted.

14. GUIDELINE MINOR AMENDMENTS (REVIEWED AND ARCHIVED)

Noted.

15. TAM REPORT

Donna Fraser provided an update.

TAM content management issues

We have been experiencing major issues with TAM software and have discovered that content has gone missing from various guidelines, which is concerning. The problem had been raised through our feedback form, which is great to know as means users are filling out the feedback and highlighting issues to us. Our concerns had been escalated to Tactuum. This is an ongoing issue and significant errors had been found with Tactuum trying to resolve it rather as quickly as possible.

The TAM Team will be meeting in person with Tactuum on 23 November and will discuss a number of issues including having more robust systems in place, analytics reports and broken links.

Update on RDS mega app

TAM will be moving over to the Right Decision Service soon and the Team were also scheduled to meet with Ann Wales on 23 November.

16. ENVIRONMENT

Focus is on inhalers. This is a many pronged approach looking at reducing inappropriate prescribing, realistic medicine, appropriate prescribing of medication, making sure that patients who use inhalers are not receiving too many.

One approach is to reduce the amount of salbutamol that is being inappropriately prescribed, another is to prescribe salbutamol by brand to prevent Ventolin being supplied against a generic prescription as there are other less environmentally harmful metered dose inhalers (MDIs) available (the formulary choice is Salamol). Another aim would be to move the appropriate patients from a metered dose inhaler to the dry powder inhaler. The Secondary Care respiratory team are to develop an education and training session for Primary Care to make sure that everyone has the same approach.

17. NHS WESTERN ISLES

For liraglutide (Saxenda), there is a prescribing protocol set up for patients to go through the dieticians for review before recommendations to GPs prescribing it. This has been shared with NHS Highland Dietetic department.

18. UPDATE TO FORMULARY SUBMISSION FORM

The following amendments were approved:

- Addition of 'Are there any specific considerations for adults with severe frailty?'.
- Addition of 'Review that section of the formulary to state which drug is first, second, third line, etc, and the place in therapy of this drug.'
- Prompts for examples of environmental implications added – 'Including eg, carbon footprint, toxicity to the environment, plastic/packaging'.

19. ANY OTHER COMPETENT BUSINESS

DMARD monitoring

DMARD monitoring was relaxed at the start of COVID and currently there is confusion about what level of DMARD monitoring there should be and there is inconsistent practice. Should it be the relaxed monitoring that was put in place under COVID or should we revert back to what we had before? DMARD monitoring guidance on TAM is extremely out of date and requires urgent review. If relaxed DMARD monitoring was OK during COVID is this generally ok? Patricia is meeting with Dermatology and Rheumatology next week to discuss a couple of additions that they want to make that they tend to use in their service, so will try for a unified guideline for these two specialities that can be put to all five. Ideas on escalation would be welcomed.
Action

20. DATE OF NEXT MEETING

Next meeting to take place on Thursday 8 December, 14:00-16:00 via TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Upadacitinib (Rinvoq) 15mg, 30mg, and 45mg prolonged-release tablets (SMC2510) *Back to minutes*	October 2022	Request clarification of place in therapy.	**PH**
Filgotinib (Jyseleca) 200mg film coated tablets (SMC2467) *Back to minutes*	October 2022	Request clarification of place in therapy.	**PH**
Dapagliflozin (Forxiga) 10mg film-coated tablets (SMC2428) *Back to minutes*	October 2022	• Place in therapy to be included in current CKD guidance and Heart Failure guidance that sits on TAM. • Request that a quick reference guide is developed from the current National guidelines. • Have the diabetes team been consulted as the guidelines suggest to refer patients to them? • There is a patient information leaflet, check to see if this would be of use. • Amend submission to 'Specialist initiation or recommendation only'.	**PH**
Hyperemesis *Back to minutes*	October 2022	• The information relevant to outpatients is right at the very end and hard to find. It would read better to change the order to outpatient management, primary care management, criteria for admission and then inpatient management. • Prochlorperazine, promethazine and chlorpromazine, are all phenothiazines so format of bullet points needs to be changed as currently unclear. • Domperidone is mentioned but safety has not been demonstrated for its use. Need to be clear where there is or there is not a risk associated with domperidone. • In the flow chart ondansetron is not mentioned but it is in the guidance. • Use of two drugs at once (if one is not working, you don't stop it and start another one, you add another one) is in the guidance but is not in the flow chart. • Lack of information on Pabrinex dosing or how to use it. Should the refeeding protocols be used? Thromboprophylaxis is unclear; assuming it is for inpatients only but clarification required. • In the flow chart highlight the two different classes and if they are using a 1st or 2nd line option. • IV ranitidine is mentioned and it is not available. • Clarify who is to get folic acid.	**PH**
Hyperosmolar Hyperglycaemic State (HHS) in adults *Back to minutes*	October 2022	• On page 2, specify that if you run the bag of potassium at the same rate as detailed on the first page patient requires ECG monitoring and central line access.	**PH**

		• Dose information required for enoxaparin in the first hour. • The first box needs to be reformatted.	
Groin hernia pathway *Back to minutes*	October 2022	Amend to 'referral for ultrasound will not be accepted' to improve clarity.	**PH**
Attention deficit hyperactivity disorder *Back to minutes*	October 2022	• More information to be provided regarding Medication indicated within the pathway. • The NICE guidance refers to shared care protocols. Clarity about how the prescription and monitoring is working would be useful. Also useful to have some guidance on how and when it might be appropriate to take on a private initiated prescription. • There is a lot of information in the FAQs which would sit better as a guideline. • The guidance from the Royal College of Psychiatrists and from NAIT to be shared. • Should this Group recommend to ADTC that NHS Highland look to writing a policy to provide advice for prescribers and other clinicians on private healthcare prescribing? • Is it possible to have a list of approved private healthcare organisations? Question to be put to ADTC. • National guidance on the split between private and NHS prescriptions to be taken forward through ADTC and see that CAG has an oversight on it.	**PH**
Adult oral analgesia *Back to minutes*	October 2022	To be resubmitted due to a number of questions regarding the guidance.	**PH**
Teicoplanin *Back to minutes*	October 2022	Include under monitoring what tube they send it in.	**PH**
Adults with asthma *Back to minutes*	October 2022	• The document states: 'This material has not been developed for patient use and should not be shared with patients'. Is it appropriate to put on TAM? Agreed it could be hosted on the Intranet with only a link being put on TAM. • Another statement in the document reads 'the material is not intended to amount to advisable advice on which you should rely' therefore how useful is the document? • Hard to read, with a lot of acronyms. • When it says criteria to identify patients at risk, does that mean that we' are we supposed to go out and actively do that? It was noted that there is at least one project looking at patients who are on excess salbutamol inhalers, should the project or the guidance come first? • These items are mentioned in the poster are they available in NHS Highland: Do we have a severe asthma clinic in NHS Highland? Do we have access to a pre-clinic test in secondary care? Is this guidance relevant locally? Would it be more appropriate to put in Highland if you are going to refer to our	**PH**

		clinic, could you do these blood tests and a sputum culture? And then refer them? • Recommend that this company supported document is rewritten to be more NHS Highland appropriate.	
Any other competent business – DMARD monitoring *Back to minutes*	October 2022	Ideas on escalation to be put forward.	**ALL**