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
16 February 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 Jenny Munro, AP Physiotherapist, Continence and Independent Prescriber Joanne McCoy, LGOWIT Manager Dr Antonia Reed, GP Dr Robert Peel, Consultant Nephrologist Dr Alan Miles, GP Claire Wright, Acute Pain Nurse Linda Burgin, Patient Representative Kirsten McCulloch, Area Renal Pharmacist
In attendance:	Wendy Anderson, Formulary Assistant Donna Fraser, TAM Project Support Manager Lewis Mitchell, 4th Year Medical Student
Apologies:	No apologies received

1. WELCOME AND APOLOGIES

The Deputy Chair welcomed the group.

2. REGISTER OF INTEREST

No interests were declared.

3. MINUTES OF MEETING HELD ON 8 December 2022

Chair joined the meeting. Minutes accepted as accurate.

4. FOLLOW UP REPORT

Noted.
Mental Health guidance: Karen MacAskill, Lead Pharmacist in Mental Health, has prioritised updating Mental Health guidance. It is in the early stages of review with meeting dates currently being set.

5. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

5.1. Haematology Chemotherapy formulary submissions

No submissions received.

5.2. Oncology Chemotherapy formulary submissions

All accepted. Noted that the previous request to ensure that environmental information is completed has yet to be done. To make it a useful exercise a spreadsheet will be created to compile this information and will include that for all formulary submissions to start collecting data for future use.

Drug (name, form, strength and manufacturer)	SMC number & status
Apalutamide (Erleada®) 60mg film-coated tablets Janssen-Cilag Ltd	SMC2472 05/08/22 – Full submission. Accepted for use.
Avelumab (Bavencio®) 20mg/mL concentrate for	SMC1315/18

solution for infusion Merck KGaA/Pfizer	06/04/18 – Full submission considered under the ultra-orphan and end of life process. Accepted for use. SMC2248 04/09/20 – Full submission assessed under the end of life process. Accepted for use.
Crizotinib (Xalkori®) 200mg and 250mg hard capsules Pfizer Limited	SMC1329/18 04/05/18 – Full submission assessed under the ultra-orphan medicine process. Accepted for use.
Dabrafenib (Tafinlar®) 50mg and 75mg hard capsules Novartis Pharmaceuticals UK Ltd	SMC2131 11/01/19 – Full submission. Accepted for use.
Everolimus (Afinitor®) 2.5mg, 5mg and 10mg tablets Novartis Pharmaceuticals UK Ltd	SMC1215/17 13/01/17 – Full submission assessed under the ultra-orphan medicine process. Accepted for use.
Ipilimumab (Yervoy®) 5mg/mL concentrate for solution for infusion Bristol-Myers Squibb	SMC2094 07/09/18 – Abbreviated submission. Accepted for use.
Lenvatinib (Kisplyx®) 4mg and 10mg hard capsules Eisai Limited	SMC2476 06/05/22 – Abbreviated submission. Accepted for restricted use.
Mobocertinib 40mg hard capsules (Exkivity®) Takeda UK Ltd	SMC2516 09/12/22 – Full submission assessed under the end of life and orphan equivalent process. Accepted for use.
Neratinib (Nerlynx®) 40mg film-coated tablets Pierre Fabre Limited	SMC2251 10/07/20 – Full submission. Accepted for use.
Nivolumab (Opdivo®) 10mg/mL concentrate for solution for infusion Bristol-Myers Squibb Pharmaceuticals Ltd	SMC1187/16 07/10/16 – Full submission assessed under the end of life and orphan equivalent process. Accepted for restricted use. SMC2458 05/08/22 – Full submission. Accepted for use. **SMC2503** (yet to be published) 13/01/23 – Full submission. Accepted for use.
Pembrolizumab (Keytruda®) 50mg powder for concentrate for solution for infusion and 25mg/mL concentrate for solution for infusion Merck Sharp and Dohme (UK) Ltd	SMC1296/18 09/02/18 – Full submission under then end of life and orphan medicine process. Accepted for restricted use.
Pembrolizumab (Keytruda®) 25mg/mL concentrate for solution for infusion Merck Sharp and Dohme (UK) Ltd	SMC2460 09/09/22 – Full submission under the end of life and orphan equivalent medicine process. Accepted for restricted use. SMC2474 09/09/22 – Full submission under the end of life and orphan equivalent medicine process. Accepted for restricted use. SMC2479 09/09/22 – Full submission. Accepted for use. **SMC2501** (yet to be published) 13/01/23 – Full submission. Accepted for restricted use.
Regorafenib (Stivarga®) 40mg film-coated tablets Bayer plc	SMC1316/18 06/04/18 – Full submission assessed under the end of life process. Accepted for use.
Ribociclib (Kisqali®) 200mg film-coated tablets Novartis Pharmaceuticals UK Ltd	SMC2198 04/10/19 – Full submission assessed under the end of life and orphan medicine process. Accepted for restricted use.
Sorafenib (Nexavar®) 200mg film-coated tablets Bayer Plc	SMC1055/15 05/06/15 – Full submission assessed under the end of life and ultra-orphan process. Accepted for use.
Tepotinib (Tepmetko®) 225mg film-coated tablets	SMC2535

Merck Serono Ltd	09/12/22 – Resubmission assessed under the end of life process. Accepted for use.

5.3. Sodium zirconium cyclosilicate (Lokelma) 10g power for oral suspension (SMC2515)
Submitted by: Jo Garrod, Area Renal Pharmacist
Indication: For the treatment of hyperkalaemia in adult patients. SMC restriction: in the emergency care setting for the treatment of acute, life-threatening hyperkalaemia alongside standard care.
Comments: It was hoped that hyperkalaemia guidance would be ready to submit to the April meeting. (Confidential information excluded.)
Ensure that the guideline author is aware that there may be other medications available which should be considered within the hyperkalaemia guidance. However, as the hyperkalaemia guidance is considerably out of date, this should not delay the guidance coming to Subgroup.
ACCEPTED
Action

5.4. Stiripentol (Diacomit) 250mg and 500mg hard capsule, 250mg and 500mg powder for oral suspension in sachet (SMC524/08)
Submitted by: Joan Mackintosh, Clinical Pharmacist Team Manager
Indication: In conjunction with clobazam and valproate as adjunctive therapy of refractory generalised tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (SMEI; Dravet's syndrome) whose seizures are not adequately controlled with clobazam and valproate.
ACCEPTED

5.5. Naloxegol (Moventig) 12.5mg and 25mg film-coated tablets (SMC1106/15)
Submitted by: Anna Falconer, Pharmacist (Gastroenterology)
Indication: The treatment of opioid-induced constipation in adult patients who have had an inadequate response to laxative(s).
Comments: The addition of naloxegol is in line with the SACT guidelines, which also contains methylnaltrexone. These guidelines are currently under review and, if changed, the Formulary Pharmacist will be informed.
ACCEPTED

6. NEW FORMULARY GUIDANCE FOR APPROVAL

6.1. Critical Care Formulary – IV Beta Blocker for Hypertension

- States atenolol shouldn't be used in renal impairment or dialysis patients – what is the rationale behind this? Comments from renal pharmacist and consultant that this is not needed and should be removed.
- Labetalol – include percentage of glucose.
- Aortic dissection section – should there be a maximum total dose?
- There are two different rates for central and peripheral administration; this should be stated more clearly.

ACCEPTED pending
Action

6.2. Out of Hours Formulary: Highland HSCP

- The correct pre-packs need to be made available.
- Amoxicillin dose has gone up to 1g three times daily. Should pack size be increased to 30?

ACCEPTED
Action

7. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS

Noted and approved.

8. FORMULARY REPORT

Noted.

9. SMC ADVICE

Noted.

10. NEW TAM GUIDANCE FOR APPROVAL

10.1.Armed Forces and Veterans

- Positive discrimination should only be made for any condition directly related to their service. This document is only to raise background awareness and identify this cohort of patients. JW to speak to submitter to ensure greater clarity of the intended message.
- Recommend to the author that Dental and Ophthalmology are made aware of the guidance.
- Further information for Healthcare Professionals link has been added.
- How is dissemination/awareness going to take place? Recommend that it is sent in the weekly bulletin, which gets sent to GP practice managers.

ACCEPTED pending

Action

10.2. Refugee and Asylum Seeker Support

ACCEPTED

10.3. ADHD Pilot Pathway

- This is a very lengthy document. Request that a shortened version of the treatment section be given as a quick reference guide.
- Noted that the assessment and treatment pathway image is very blurry. Explanation given that flowcharts have been an ongoing issue on TAM and no tool has yet been able to provide an adequate flowchart for TAM. There is a meeting arranged with an MS365 trainer to seek a solution.
- Feedback from GP representatives:
  - The referral criteria is too onerous to be able to be completed in the primary care clinic setting and is not a realistic expectation.
  - As a guideline the referral criteria cannot be mandated. If this to be mandatory then a SCI gateway referral with absolute referral requirements should be created, and a guideline to reflect these absolute requirements and what other referral information would be useful.
  - From experience; even when all the referral criteria is completed, the referral is still rejected, therefore suggests that the system within which the referral sits needs to come into realistic alignment.
- Noted that the pathway leads to medication treatment pathway only. At the December 2022 Subgroup the author explained that the non-medication pathway is not able to be implemented yet and it was felt that guidance was needed while waiting for the full service. This clarity should be included in the guideline. Request that the reason a medication pathway only is available should be stated in the guideline.

ACCEPTED

Action

10.4. Intravenous mannitol to reduce raised intraocular pressure

- Concern that this reads as an instruction to administer and therefore may be misinterpreted, particularly in the out of hours setting. The format reads as a PGD. Should this be on TAM?
- Who gives the authority for administration?
- Is it aimed at in hours or out of hours?

REJECTED

Action

11. GUIDELINE UPDATES

11.1. Achieving control in Type 2 diabetes

- Amendments were accepted, however it was noted that the criteria for flozins use to lower blood sugar higher in the document also needs to refer to its use for other indications.

ACCEPTED

Action

11.2. Stress and distress in dementia

ACCEPTED

11.3. Out of Hours guidelines

- Amend Audience to Primary Care only.

ACCEPTED pending

Action

12. GUIDELINE MINOR AMENDMENTS

Noted and approved with the exception of:

- UTI guidance – the information on TAM (trimethoprim should be avoided in the first trimester, but this can be over ruled at consultant level) appears to conflict with the information linked to in the UTI maternity guidelines (trimethoprim should not be used in the third trimester). Request that the guidance is brought into alignment instated in both places.

Action

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

Imagine pathway for Primary Care direct access to CT chest/abdomen/pelvis for suspected malignancy.

14. GUIDELINE DELETIONS

COVID-19 guidance review: *guidance no longer required or assimilated into standard guidance*

- COVID020 Sexual Health
- COVID021 Skin COVID 19
- COVID006 Diabetes COVID-19
- COVID052 End of life Acute COVID-19
- COVID004 Cancer COVID-19
- COVID102 Anticoagulant COVID-19
- COVID019 Rheumatology COVID-19
- COVID078 Emergency management of tracheostomy patient on LTV
- DMARDs during COVID: *replaced with DMARD monitoring in Primary Care*

TAM387 Incontinence dermatitis: *Request to be removed by author*
FCR110 Inner Moray Firth Investigation and Treatment Room Service: *significantly out of date*
TAM299 Cervical smear recall: *significantly out of date*
TAM302 Management following colposcopy: *significantly out of date*

15. TAM REPORT

A brief update was provided.

- TAM Support Manager Post: Donna Fraser will be leaving her fixed term contract on 23 February. She was thanked for her excellent work during a challenging period. Laura Cuthbertson will be returning from maternity leave on 14 April to reduced hours of 0.8wte. There will therefore be a gap in staffing during this period where only essential work will be able to be carried out:
    - The actions from this Subgroup will be actioned next week, and the Subgroup should expect reduced guidance paperwork for the April Subgroup.
    - Due to the lack of staff the workload generated from the annual departmental reviews, which started last January would not be able to be done, therefore, with the exception of two, Mental Health and Antimicrobial, they have not been conducted this year. These services have engaged and, if able to be completed will significantly reduce the number of out of date guidance, which is a concern for TAM. If workload then allows other departments to be targeted are Haematology and Vascular. Instead the guidance which is most out of date, and has had no response from authors, will be brought to Subgroup to assess if it can be safely removed.
    - TAM is due to move over to the Right Decisions for Health and Care software in March. This work will proceed as the background work will be undertaken by Tactuum (a software company) and will not impact on TAM workload until there is sufficient staff to accuracy check the transfer. For a period of time both systems can run, TAM RDS will only be made available and current TAM be removed from use when approved by NHS Highland. This will include a system that will send out automatic reminders to authors of out of date guidance.

16. ENVIRONMENT

MRC Project: Developing frameworks for eco-directed sustainable prescribing: Towards reducing environmental pollution from healthcare practices

NHS Highland, the University of the Highlands and Islands – Environmental Research Institute (ERI), and the University of Nottingham have been awarded a UK Research & Innovation grant of £100,000 from the MRC to develop a framework for an eco-directed formulary. The project is being led by Sharon Pfleger, Consultant in Public Health, NHS Highland. The research will use pre-existing prescribing and environmental data and will,

through focus groups, incorporate the views of organisational stakeholders, prescribers and patients. The research aims to generate new knowledge and awareness of the environmental impact of medicines. This is a first step towards improvement of medicine prescribing in Scotland to reduce pollution that seeks to enable better informed and more sustainable prescribing choices.

The anticipated outcomes are:

- The introduction of new (to the NHS) data sources as indicators of environmental impact into the formulary process.
- The development of a robust decision-making framework for formulary recommendations that can be built on and adopted at UK- and international-level.
- Increased awareness amongst healthcare practitioners, prescribers, pharmacists, and the public of the environmental impact of medicines.

The project has senior level support from NHS Highland's Board and Chair, its CEO and the Directors of Public Health, Medicine and Pharmacy. The project is already under way, with the background work having started in October of last year. The first Project Stakeholder Group took place at the end of January and was well attended, with the attendance of senior members of the Scottish Government Health Department and interest from other parts of the UK, including NICE.

PH and FH, along with Tracy Beauchamp, the Pharmacy Data Analyst Specialist, are participating from NHS Highland, bringing their expertise of Formulary processes and management and the utilisation of prescribing data.

17. NHS WESTERN ISLES

Nothing to report.

18. ANY OTHER COMPETENT BUSINESS

TAM staffing as per the TAM report

TAM paperwork: Those able to access Teams found this to be useful. Agreed to continue to provide meeting papers as a folder on Teams, to provide a link to this folder with the meeting invite and to include the folder as an attachment to the invitation email thereby ensuring that those who cannot access Teams have the same paper set.

19. DATE OF NEXT MEETING

Next meeting to take place on Thursday 27 April, 14:00-16:00 via TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Sodium zirconium cyclosilicate (Lokelma) 10g power for oral suspension (SMC2515) *Back to minutes*	February 2023	Ensure that the guideline author is aware that there may be other medications available which should be considered within the hyperkalaemia guidance.	**PH**
Critical Care Formulary – IV Beta Blocker for Hypertension *Back to minutes*	February 2023	• States atenolol shouldn't be used in renal impairment or dialysis patients – what is the rationale behind this? Comments from renal pharmacist and consultant that this is not needed and should be removed. • Labetalol – include percentage of glucose. • Aortic dissection section – should there be a maximum total dose? • There are two different rates for central and peripheral administration; this should be stated more clearly.	**PH**
Out of Hours Formulary: Highland HSCP *Back to minutes*	February 2023	• The correct pre-packs need to be made available. • Amoxicillin dose has gone up to 1g three times daily. Should pack size be increased to 30?	**PH**

Armed Forces and Veterans *Back to minutes*	February 2023	• Positive discrimination should only be made for any condition directly related to their service. This document is only to raise background awareness and identify this cohort of patients. JW to speak to submitter to ensure greater clarity of the intended message. • Recommend to the author that Dental and Ophthalmology are made aware of the guidance. • Further information for Healthcare Professionals link has been added. • How is dissemination/awareness going to take place? Recommend that it is sent in the weekly bulletin, which gets sent to GP practice managers.	**JW/PH**
ADHD Pilot Pathway *Back to minutes*	February 2023	• Request that a shortened version of the treatment section be given as a quick reference guide. Feedback from GP representatives: • The referral criteria is too onerous to be able to be completed in the primary care clinic setting and is not a realistic expectation. • As a guideline the referral criteria cannot be mandated. If this to be mandatory then a SCI gateway referral with absolute referral requirements should be created, and a guideline to reflect these absolute requirements and what other referral information would be useful. • From experience; even when all the referral criteria is completed, the referral is still rejected, therefore suggests that the system within which the referral sits needs to come into realistic alignment. Noted that the pathway leads to medication treatment pathway only. At the December 2022 Subgroup it had been explained that the non-medication pathway is not able to be implemented yet and it was felt that guidance was needed while waiting for the full service. This clarity should be included in the guideline. Request that the reason a medication pathway only is available should be stated in the guideline.	**PH**
Intravenous mannitol to reduce raised intraocular pressure *Back to minutes*	February 2023	• Concern that this reads as an instruction to administer and therefore may be misinterpreted, particularly in the out of hours setting. The format reads as a PGD. Should this be on TAM? • Who gives the authority for administration? • Is it aimed at in hours or out of hours?	**PH**
Achieving control in Type 2 diabetes *Back to minutes*	February 2023	Criteria for flozins use to lower blood sugar higher in the document also needs to refer to its use for other indications.	**PH**
Out of Hours guidelines *Back to minutes*	February 2023	Amend Audience to Primary Care only.	**PH**
Guideline minor amendments *Back to minutes*	February 2023	UTI guidance – the information on TAM	**PH**

		(trimethoprim should be avoided in the first trimester should be avoided, but this can be over ruled at consultant level) appears to conflict with the information linked to in the UTI maternity guidelines (trimethoprim should not be used in the third trimester). Request that the guidance is brought into alignment instated in both places.	