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
9 December 2021, via Microsoft TEAMS

Present:	Alasdair Lawton, Chair Patricia Hannam, Formulary Pharmacist Dr Alan Miles, GP Dr Robert Peel, Consultant Nephrologist Louise Reid, Acute Pain Nurse Lead Claire Wright, Acute Pain Nurse Dr Jude Watmough, GP Susan Caldwell, Principal Pharmacist Joanne McCoy, LGOWIT Co-ordinator Linda Burgin, Patient Representative Dr Duncan Scott, Consultant Physician Dr Simon Thompson, Consultant Physician Wendy Smith, Patient Representative
In attendance:	Kate Arrow, Consultant, Anaesthetics Julie Handley, Pharmacy Care Clinical Pharmacist (Lochaber) Wendy Anderson, Formulary Assistant Laura Macdonald, TAM Project Support Manager
Apologies:	Dr Antonia Reed, GP Ayshea Robertson, Associate Lead Nurse Argyll & Bute Findlay Hickey, Principal Pharmacist (Medicines Management and Prescribing Advice)

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

No interests were declared.

3. MINUTES OF MEETING HELD ON 28 OCTOBER 2021

Accepted as accurate.

4. FOLLOW UP REPORT

A brief verbal update was given with the following being noted:

- Add in date of February 2022 for emollients discussion with Dermatology.
- Lidocaine action is now also complete.

5. REALISTIC MEDICINE PRESENTATION

Kate Arrow, Consultant, Anaesthetics provided an informative presentation regarding realistic medicine. There are six pillars which TAM already encompasses. Current focus includes:

- supporting the workforce to be able to deliver really good patient care
- sustainability; not only financially but environmentally
- engaging patients in new and innovative ways.

It is hoped that the Realistic Medicines umbrella can help to bring different strings of work together to provide some support and integration so that people are sharing their practice and workload and duplication is reduced. Realistic Medicines brings together different specialities who can then work together on shared speciality areas eg end of life care and treatment escalation.

Discussion took place with the following comments being made:

- All lot of what we do within the TAM Subgroup is affected by Realistic Medicines and vice versa so going forward there will be a lot of linkages and overlap.
- A cultural shift will need to happen within hospital and public. Good communication and full public consultation needs to occur to keep the public informed.
- How do we embed this into the Formulary and TAMSG decision making? How does it fit with both the environmental concerns and a lot of guidance is authorised which often increases the amount of investigations rather than decreasing investigations? What may be realistic for one population group but not for others eg elderly patients so careful consideration needs to be made on how guidance and medicines are authorised.
- This is a multi-layered and a huge piece of work but progress is being made. The realistic medicine, the environment and deprescribing polypharmacy are all linked. A presenter will be invited to attend the next meeting to talk about deprescribing. Providing all this information to the Group informs the Group to gain an understanding of the influence that this Group can make. Other ways it can be affected is by embedding, similar to the five questions of patient information, Realistic Medicine directed questions into guidelines, we already ask about self-management options, place in therapy, and if a drug is added is another removed. Further discussion to take place out with the group on improving the current checklist with the following potentially being added if not already included:
    - consider brand.
    - is this patient centred?
    - does it promote shared decision making?
    - is it the most financially and environmentally sustainable option?
    - will it promote or reduce variation in practice?
- Suggestions for patient representative involvement for working with the strategy in realistic medicine to be discussed.

Action

6. CONSIDER FOR APPROVAL ADDITIONS TO FORMULARY

Methoxyflurane has now been accepted and added to the Formulary.

6.1. Guselkumab (Tremfya) 100mg solution for injection in pre-filled pen or syringe (SMC1340/18)
Submitted by: Dr K Woo, Consultant Dermatologist
Indication: Treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. Restriction: for patients who have failed to respond to conventional systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contraindication to these treatments.
ACCEPTED

6.2. Brentuximab vedotin (Adcetris) 50mg powder for concentrate for solution for infusion (SMC2310)
Submitted by: Dr Peter Forsyth, Consultant, Haematology
Indication: In combination with cyclophosphamide, doxorubicin and prednisone (CHP) for adult patients with previously untreated systemic anaplastic large cell lymphoma (sALCL).
ACCEPTED

6.3. Lenalidomide (Revlimid) 2·5mg, 5mg, 7·5mg, 10mg, 15mg, 20mg and 25mg hard capsules (SMC2281)
Submitted by: Dr Peter Forsyth, Consultant, Haematology
Indication: In combination with rituximab (anti-CD20 antibody) for the treatment of adult patients with previously treated follicular lymphoma (Grade 1 to 3a).
ACCEPTED

6.4. Polatuzumab vedotin (Polivy) 140mg powder for concentrate for solution for infusion (SMC2282)
Submitted by: Dr Peter Forsyth, Consultant, Haematology
Indication: In combination with bendamustine and rituximab for the treatment of adult patients with

relapsed or refractory diffuse large B-cell lymphoma who are not candidates for haematopoietic stem cell transplant.
Comment: Noted that the costing and DOI details are missing from the form. DOI has been confirmed via email and the costing information requested. These had been completed but had not transferred across.
ACCEPTED

6.5. Caplacizumab (Cablivi) 10mg powder and solvent for solution for injection (SMC2266)
Submitted by: Dr Peter Forsyth, Consultant, Haematology
Indication: Treatment of adults experiencing an episode of acquired thrombotic thrombocytopenic purpura (aTTP), in conjunction with plasma exchange and immunosuppression.
Comments: Note re zero costing data on the form. Understood that patients do not receive this treatment in NHS Highland and that there has been a change in how patients access this treatment. To clarify how patients are to access this treatment, whether stock is to be obtained locally and, if so, does the stock holding/shelf life allow for this, and to confirm the cost implications of this change.
ACCEPTED pending
Action

7. UPDATED AND NEW TAM GUIDANCE FOR APPROVAL

7.1. Palpitation and Tachycardia in Pregnancy

- In the Intermediate Risk box it doesn't state for echocardiogram how urgent it is or if it is an inpatient or outpatient. Add in 'consider updating previous echo'. Change last sentence to 'If significant arrhythmia or clinical worry seek senior advice'.
- How long is the waiting time for an ambulatory ECG?

REJECTED
Action

7.2. HIV Pre-Exposure Prophylaxis (PrEP)

- To request addition: Blood tests can be done by ITR, as appropriate.
- Out with this meeting, discussion to take place on what guidance needs to go to GP Subcommittee as this guidance may have benefited from doing so.

ACCEPTED
Action

7.3. Transmale and Transfemale guidance

Transmale

- More information needed re CHI numbers. How do clinicians know whether the patient is to be considered male or female for monitoring purposes and whether the CHI number has been changed?
- Check haematocrit level is correct should this be based on the gender pre or post transition?

Transfemale

- More information needed re CHI numbers. How do clinicians know whether the patient is to be considered male or female for monitoring purposes and whether the CHI number has been changed?

REJECTED
Action

7.4. NHSH Imaging Pathway for Primary Care Direct Access to CT for Suspected Malignancy - Referral Criteria

- More information may be required on what happens after you get the CT report, in particular, metastatic cancer of unknown origin. This information is given in the accompanying FAQs. It may need to be more explicit as to where GPs refer the patient to.
- When is this service going to rolled out and be accessed? How is going to be disseminated?
- Agreed that service should be reviewed after 6 months and update the FAQ document as appropriate.

ACCEPTED
Action

7.5. FAQ for GP CT Referral for Cancer Pathway
ACCEPTED

7.6. Management of Acute Upper GI Bleed (AUGIB)

- For use in secondary care.
- Add in an explicit do not use tranexamic acid statement.

ACCEPTED

Action

7.7. Management of stress and distress in dementia

- Quick reference guides should be written.

ACCEPTED

Action

7.8. Casirivimab and imdevimab for confirmed SARS-CoV-2 infection

ACCEPTED

7.9. Hypomagnesaemia

- Add omeprazole to Aetiology section.
- Intravenous magnesium states 'not for patients with heart block or existing myocardial damage', what do you do with these patients?

REJECTED

Action

7.10. Hypokalaemia

- Comments to be received after the meeting from Dr Peel.

REJECTED

Action

7.11. Hypocalcaemia

- Comments to be received after the meeting from Dr Peel.

REJECTED

Action

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

Noted:

Severe Sepsis – Unknown Focus
Community Mental Health Team (CMHT)
Seroma drainage following breast surgery
Guillain Barre Syndrome
Length Dependent Neuropathies
Headache
Differential diagnosis of common respiratory conditions
COPD (Chronic Obstructive Pulmonary Disease)
Oxygen
Embolism prophylaxis for patients with non-valvular*, persistent or permanent atrial fibrillation (AF)

9. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS AND GUIDELINE MINOR AMENDMENTS

Formulary minor additions/deletions/amendments

Noted and approved with the following specifically mentioned:

- Agreed not to specify diclofenac as diclofenac potassium or sodium unless there are cautions or concerns with one or the other.
- Removed dexamethasone soluble tablets as the standard tablets can be dissolved. This information will be included in the Croup guidance. Further agreed to add dexamethasone liquid to the croup guidance as a non-Formulary item.
- Darbepoetin – agreed to change to 'All patients on darbepoetin'.
- Isoprenaline hydrochloride – agreement to take place between Patricia, Susan and Jane as to whether this should be added back on to the unlicensed medicines list as currently only unlicensed is available.

Guideline minor amendments

Noted and approved pending comments below.

- COVID-19 vaccines – add link to green book for latest guidance and include vaccine names.

Action

10. FORMULARY REPORT

This report is done on a national level every quarter and data is then pulled locally. It is useful for tracking drugs through the Project Management Office and this Group.

11. TAM REPORT

Work is progressing on reducing the amount of out of date pieces of guidance.

12. TAM RISK REGISTER

Out of date guidelines is the biggest risk for TAM and currently a big drive is taking place to contact all the authors for the out of date guidance. The initial risk is pre-mitigation, rather than have a target risk have a post-mitigation risk. The Current Risk Score should be post-mitigation risk so that it is clear what real risk is left.

How are we managing authors? A move is being made towards departmental responsibility rather than individuals, with it being managed through service managers so there is a departmental oversight of guidance. A plan has currently been trialled with three departments before roll out in January to send a spreadsheet to each department listing all the guidance that it has on TAM and whether it is in date or out of date. The idea would be that they can then identify any gaps in the guidance with review dates. From a practical point of view results tend to work better if a job role/post is targeted rather than a department which in this instance should be the service manager.

Transcription errors on TAM are the second largest risk. Work has been underway to standardise how guidance is being sent to the TAM team to reduce this risk. An accuracy check takes place within the TAM Team and after publishing it goes to the author to check.

13. SMC ADVICE

Noted.

14. DATIX INFORMATION

DATIX is a system within NHS Highland in secondary care whereby if there are any incidents that happen they can be recorded with the idea that they can be analysed and help to reduce errors happening in the future.

Should near misses and significant events be on TAM? In the hospital and community a newsletter already circulates about four times a year with highlighted instances. Agreed that TAM is not the best place for this information to sit.

15. BRAND PRESCRIBING

Traditionally within the NHS generic prescribing has been encouraged, however with cost and environmental implications we are being pushed to prescribe particular brands. This has implications for primary care in being asked to do switches. Should the Formulary promote particular brands or should this be done elsewhere? Should brand prescribing be dictated or encouraged? The following comments were made:

- There are important instances where brand prescribing can be beneficial for cost or the environment.
- For instances where the product is cheaper and equally efficacious then this information can be given in TAM guidance. This instruction should come from the specialists who use the drug though.
- The information will need to be reviewed regularly to ensure the benefit is still in place.
- Could the information go on Scriptswitch?
- Would the Community Pharmacists be able to champion this as they have the knowledge on how to access the information and have the ability to review those drugs with the patients, rather than the GP?

Action

16. NHS WESTERN ISLES

Nothing to report.

17. ANY OTHER COMPETENT BUSINESS

Shared Care Protocols in NHS Highland

Shared Care is when a medicine is normally prescribed in secondary care that is usually complex and may require monitoring or cause adverse reactions. It would initiated by secondary care but once the patient is stabilised, the secondary care clinician may ask primary care to prescribe it. Currently there is no policy for shared care of medicines so this will be raised at the next ADTC meeting and a request made as to whether NHS Highland should have a policy. After this it will go through the standard channels, with GP Subcommittee being part of the collaborators in developing the policy.

Scottish Intercollegiate Guidelines Network (SIGN) Guidance
Not discussed.

18. DATE OF NEXT MEETING

Next meeting to take place on Thursday 24 February, 14:00-16:00 via TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Realistic Medicine *Back to minutes*	December 2021	Further discussion to take place out with the group on improving the current checklist.	**PH/KA**
	December 2021	Suggestions for patient representative involvement for working with the strategy in realistic medicine to be discussed.	**PH/WS**
Caplacizumab (Cablivi) 10mg powder and solvent for solution for injection *Back to minutes*	December 2021	To confirm how patients are to access this treatment, eg from another Health Board, to confirm the stock holding/shelf life arrangements and the cost implications.	**PH**
Palpitation and Tachycardia in Pregnancy *Back to minutes*	December 2021	Edit detail, change and to an. In the Intermediate Risk box it doesn't state for echocardiogram how urgent it is or if it is an inpatient or outpatient. Add in 'consider updating previous echo'. Change last sentence to 'If significant arrhythmia or clinical worry seek senior advice.	**PH**
	December 2021	How long is the waiting time for an ambulatory ECG?	**PH**
HIV Pre-Exposure Prophylaxis (PrEP) *Back to minutes*	December 2021	To request addition: Blood tests can be done by ITR, as appropriate.	**PH**
	December 2021	Discussion to take place on what guidance needs to go to GP Subcommittee.	**PH/AM**
Transmale *Back to minutes*	December 2021	More information needed re CHI numbers. How do clinicians know whether the patient is to be considered male or female for monitoring purposes and whether the CHI number has been changed?	**PH**
	December 2021	Check haematocrit level is correct. Should this be based on the gender pre or post transition?	**PH**
Transfemale *Back to minutes*	December 2021	More information needed re CHI numbers. How do clinicians know whether the patient is to be considered male or female for monitoring purposes and whether the CHI number has been changed?	**PH**
NHSH Imaging Pathway for Primary Care Direct Access to CT for Suspected Malignancy - Referral Criteria *Back to minutes*	December 2021	When is this service going to rolled out and be accessed? How is going to be disseminated?	**PH**
	December 2021	Agreed to review the service after 6 months and update the FAQ document as appropriate.	**PH**
Management of Acute Upper GI Bleed (AUGIB)	December 2021	Add in an explicit do not use tranexamic acid statement.	**PH**

Back to minutes			
Management of stress and distress in dementia *Back to minutes*	December 2021	Request that quick reference guides be written for carers, care homes and GPs.	**PH**
		Request that the guideline is actively sent to care homes.	**PH**
Hypomagnesaemia *Back to minutes*	December 2021	Add omeprazole to Aetiology section.	**PH**
	December 2021	For intravenous magnesium, request from author happens to patients with heart block or existing myocardial damage', what do you do with these patients?	**PH**
Hypokalaemia *Back to minutes*	December 2021	Comments to be sent to Formulary Pharmacist.	**RP**
Hypocalcaemia *Back to minutes*	December 2021	Comments to be sent to Formulary Pharmacist.	**RP**
Formulary Minor additions/ deletions/amendments *Back to minutes*	December 2021	Dexamethasone liquid to be added to the croup guidance as a non-Formulary item and include information on crushing standard tablets.	**PH**
	December 2021	Darbepoetin – agreed to change to 'All patients on darbepoetin'.	**PH/WA**
	December 2021	Isporenaline hydrochloride – agreement to take place as to whether this should be added back on to the unlicensed medicines list as currently only unlicensed is available.	**PH/SC/JS**
Guideline minor amendments *Back to minutes*	December 2021	COVID-19 vaccines – ensure that this information is still in date. Request that a link to the green book and vaccine names be included.	**PH**
Brand prescribing *Back to minutes*	December 2021	Could the information go on Scriptswitch?	**PH**
	December 2021	Would the Community Pharmacists be able to champion this as they have the knowledge on how to access the information and have the ability to review those drugs with the patients, rather than the GP?	**PH**