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
28 October 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 Dr Antonia Reed, GP Dr Jude Watmough, GP Jane Smith, Principal Pharmacist Ayshea Robertson, Associate Lead Nurse Argyll & Bute Joanne McCoy, LGOWIT Co-ordinator Linda Burgin, Patient Representative
In attendance:	Gil Paget, TAM Project Manager Sharon Pfleger, Consultant in Pharmaceutical Public Health Joe Garnet, Medical Student
Apologies:	Findlay Hickey, Principal Pharmacist (Medicines Management and Prescribing Advice) Liam Callaghan, Principal Pharmacist Western Isles Wendy Smith, Patient Representative Wendy Anderson, Formulary Assistant

1. WELCOME AND APOLOGIES

The Chair welcomed the Group.

2. REGISTER OF INTEREST

No interests were declared.

3. MINUTES OF MEETING HELD ON 26 AUGUST 2021

Accepted as accurate.

4. MINUTES OF EXTRAORDINARY MEETING HELD ON 15 SEPTEMBER 2021

Accepted as accurate.

5. FOLLOW UP REPORT

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

- Agreed to remove the TAM survey and TAM training video from the follow up report as they now come under the remit of the TAM Project Manager.
- The Remit and Terms of Reference member list had been updated and were accepted.

Action

6. CONSIDER FOR APPROVAL ADDITIONS TO FORMULARY

6.1. Fremanezumab (Ajovy) for subcutaneous injection. Two dosing options are available: 225mg once monthly (monthly dosing) or 675mg every three months (quarterly dosing)

Submitted by: Francisco Javier Carod Artal, Consultant Neurologist
Indication: For prophylaxis of migraine in adults who have at least four migraine days per month.

Comments: It has a PAS in place. Specialist use only medicine. Currently there are no other treatments available equivalent to this for chronic or episode migraines.
Good detail in the submission re effectiveness, cost-analysis OK with respect to low patient numbers and good to have an alternative product for patients who are debilitated by migraines. If required, will monitoring be carried out by the specialist?
ACCEPTED pending
Action

6.2. Ofatumumab (Kesimpta) 20mg/0.4mL solution for injection in pre-filled syringe/pen
Submitted by: Francisco Javier Carod Artal, Consultant Neurologist
Indication: Treatment of adult patients with relapsing forms of multiple sclerosis (RMS) with active disease defined by clinical or imaging features.
Comments: Available subcutaneously meaning that patients can self-administer rather than having to attend an infusion suite. It has a PAS in place. First line treatment for those requiring a multiple sclerosis injection or second line treatment where disease modifying therapy escalation is required. Specialist use only.
Noted that the SMC approval is on a cost-minimisation analysis basis meaning that, while it may be more expensive than some, it is cheaper than the majority of other MS therapies. There was an appreciation that any delay of this type of treatment to this patient group would not only increase the cost of care of this patient group, but also cause increased suffering to the patient and the submission was fully supported.
ACCEPTED

6.3. Galcanezumab (Emgality) 120mg galcanezumab injected subcutaneously (SC) once monthly, with a 240mg loading dose as the initial dose
Submitted by: Francisco Javier Carod Artal, Consultant Neurologist
Indication: Prophylaxis of migraine in adults who have at least 4 migraine days per month. Restricted use: for the treatment of patients with chronic and episodic migraine who have had prior failure on three or more migraine preventive treatments.
Comments: Has a PAS in place and is specialist use only. Usefully the place in therapy is stated in this submission for both galcanezumab and framanezumab.
Erenumab is already on the Formulary for chronic migraines but this is under the category 'prophylaxis of episodic migraine', therefore to clarify with the submitter how the monograph should be presented. If required, will monitoring be carried out by the specialist?
ACCEPTED pending
Action

6.4. Guselkumab (Tremfya) 100mg solution for injection in pre-filled pen or syringe
Submitted by: Jan Sznajd, Consultant Rheumatologist
Indication: Alone or in combination with methotrexate (MTX) for the treatment of active psoriatic arthritis in adult patients who have had an inadequate response or who have been intolerant to a prior disease-modifying antirheumatic drug (DMARD) therapy.
Comments: Specialist use only. Is high cost but has a PAS in place. Will be used third line as a disease modifying agent for psoriatic arthritis.
Good that environmental impact section has been completed. Of note monoclonal antibodies are all broken down and therefore the main environmental impact will be, for example, mode of administration, production and packaging. Noted that this does not cover the indication plaque psoriasis, for which there is a submission awaiting December subgroup. To note that each SMC indication will require a separate submission as the health economics may be different for each indication. Noted that this is also SMC cost minimising.
ACCEPTED

6.5. Methoxyflurane (Penthrox) 99.9% 3ml inhalational vapour, liquid
Submitted by: Kenneth Barker, Consultant Anaesthetist
Indication: Emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain.
Comments: No SMC advice available. The main reason for this request is environmental impact as nitrous oxide is shown to be of high environmental harm. Approval of this submission will reduce some but not all use of nitrous oxide due to it not being licensed for use in paediatrics. Nitrous oxide to remain on the formulary. Could be of benefit to primary care for British Association for Immediate Care (BASICS) use. Ready access to Entonox is no longer available for some GPs due to closure of local hospital and Penthrox is challenging to obtain. Query if use can be extended for primary care and other areas eg Mountain Rescue and Community Hospitals. Cost comparison information has not been provided between Entonox and Penthrox and should be obtained and circulated to the Group. Would also be useful to see even rough numbers of how many people use Entonox in an A&E setting. Hard to provide numbers as it is

used a lot seasonally (eg for fractures). An audit is currently underway and the data can be shared. One member had done cost assessment to find that it was cost neutral or better value. BNF pricing for Penthrox available and Entonox from pharmacy procurement. Noted that there are additional costs with Entonox, such as mouthpieces and cylinder checking requirements by Medical Physics. Noted that Community Pharmacies need to be registered to hold Penthrox, if that is where GP practices would obtain it from. Submission states use in Secondary care and by the Pre-hospital Immediate Care and Trauma (PICT) team but who else could use it would depend on the Marketing Authorisation and licence. The SPC does not specifically state only to be used in Hospital setting. Benefits acknowledged of using Penthrox include easier transportability of a non-bulky object and an effective treatment that does not require IV access. Noted that ventilated rooms are required for Entonox.

REJECTED

Action

6.6. withdrawn

6.7. Macrogol 3350 with potassium chloride, sodium bicarbonate and sodium chloride (VistaPrep) oral powder 110g sachet

Submitted by: Jim Docherty, Consultant Surgeon, Clinical lead for Endoscopy

Indication: VistaPrep is used for bowel cleansing in preparation for colonoscopy. VistaPrep is indicated in adults over 18 years of age.

Comments: Submission has been made purely on the grounds of cost. Specialist use only.

ACCEPTED

7. UPDATED AND NEW TAM GUIDANCE FOR APPROVAL

7.1. Requesting Echo for TIA/Stroke *(new)*

- A glossary of terms will be included.
- Clarify that this is for Secondary care only.

ACCEPTED

Action

7.2. Diagnosing familial hypercholesterolaemia *(major update)*

ACCEPTED

7.3. Peri-operative guidelines for adults with and at risk of adrenal insufficiency *(updated)*

- Will this be incorporated into the pre-op assessment?
- Identifying patients at risk of adrenal suppression section has been pulled directly from the new steroid alert emergency cards. The inhaled steroids part in particular acts as a useful reminder and would be good to have it more prominent on TAM. Also very useful information for minor surgery (which does occur in Primary Care). Also of relevance to Dental. Noted that it details to give additional hydrocortisone to those already taking hydrocortisone but not to patients on high dose steroids so clarification to be required within the guidance. Add link to relevant Formulary monographs and include an article in the Pink One to raise awareness throughout (Dental, acute medical, Primary Care as well as peri-operatively).

ACCEPTED pending

Action

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

Noted:

Cellulitis in patients with Lymphoedema
Cellulitis - Patient information leaflet
Recurrent Cellulitis
Pain assessment and tools (Paediatric)
Naloxone and managing complications of opioids (Paediatric)
Nausea and Vomiting Assessment Tools (Paediatric)
Epidural (Paediatric)
Investigating for diabetes in children
Hypophosphataemia

9. MANAGEMENT OF COVID-19 GUIDANCE

Noted:

Venous Thromboembolism Prophylaxis (VTEP) in COVID-19 pneumonia adult medical inpatients

Oxygen (COVID-19)
Tocilizumab and Sarilumab (COVID-19)
Remdesivir for Adults and Children 12 years and older (COVID-19)
COVID-19 Clinical Evaluation
Corticosteroids (dexamethasone, prednisolone and hydrocortisone) for adults with confirmed SARS-CoV-2 infection
Casirivimab and imdevimab for patients with confirmed SARS-CoV-2 infection

A COVID-19 working group is in the place, with the Clinical Lead, Duncan Scott. Once set up any guidance will be developed and finalised by them and then passed to this Group to comment upon and approve.

Linda Burgin joined the meeting and was introduced to the Group.

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

Formulary minor additions/deletions/amendments
Noted and approved with the following specifically mentioned:

- Estradiol, Vagifem, has high plastic use and there are other more environmentally friendly products available, therefore the brand has been removed from the Formulary to allow prescribers to prescribe generically.
- Upadacitinib is already on the Formulary for rheumatoid arthritis and is listed on the minor amendments for psoriatic arthritis. It was noted that a submission should be made for every indication as the health economics for the marketing authorisation might be completely different and often the PAS discounts are also different. Further discussion to take place between RP and PH out with the meeting as to when a submission for a new indication should be made.
- There are not many shared care protocols within Highland and further discussion should be made perhaps at the next meeting. It was agreed that in the first instance this should be discussed with GP Subcommittee. NHS Fife have a good system in place and this could be used as an example. There is a risk of creating too much bureaucracy and paperwork with developing a lot of shared care protocols and they should only be put in place for patient benefit. Some new medications are more complex with a lot of side effects so we need to be cautious and mindful of this, so how do we make sure the information is disseminated and people are aware.

Guideline minor amendments
Noted and approved pending comments below.

- Computerised cognitive behavioural therapy, notification about the Silvercloud additional modules would be beneficial.
- Heart failure – add MRA to the glossary.
- Sennosides consideration to given to the addition of the phrase ‘previously known as senna’

Action

11. TAM REPORT AND INTRODUCTION TO TAM PM

Noted that there was a high number of out of date COVID guidance, this was because initially the guidance had been given a short 3-month expiry date. Work is underway to review this section.

Gil Paget, TAM Project Manager provided a presentation on the review of the Treatment and Medicines Portal (TAM). *(Presentation saved in the meeting folder).*

The following comments were made:

- Great presentation and a very important role. TAM is incredibly useful for Primary and Secondary Care and it has developed over the years into what NHS Highland offers Clinicians, so investment should be made in managing it appropriately and reviewing the risks that are associated with having something that is so widely used and yet has so many out of date guidelines on it.
- Good to see that focussing in on referrals and that information is being made clear. Nice idea to have waiting times easily accessible as information is key to the patient. Commented that If NHS Highland could do one thing to alleviate patient pressures, it would be to make this information available.

- What are next steps to secure additional resource? A business case would need to be put together. It has been identified that there is a requirement for a Patient Information Officer but this post would not necessarily sit within the TAM structure. The Formulary Pharmacist does a significant amount of work that isn't within her remit and a TAM Manager that deals with non-medicine guidance could resolve this.
- Structures are currently being put in place for guidance and discussion underway with the Medical and Assistant Medical Directors to support departmental ownership of guidance.
- The TAM Subgroup were reminded that the current staffing for TAM is one band 4 Project Support Manager, and now the 1-year seconded Project Manager post.

12. FORMULARY AND THE ENVIRONMENT

Sharon Pfleger, Consultant in Pharmaceutical Public Health, introduced herself and explained that her role covers the environmental impact of medicines. She provided an update that things have moved on and in the last 3 or 4 years they have been getting the message out about the impact of pharmaceuticals in the environment. Medicines and the environment, why do they matter? Twenty-five percent of the NHS's carbon footprint comes from medicines albeit that most of that is the procurement end but about 3 to 4% comes from inhalers and the same from anaesthetic gases. So we can have an immediate effect of reducing the impact. There are three main ways that medicines can have an impact:

- Carbon footprint – how much energy is used, emissions put out in the development, the transport and the use of the medicine.
- Direct biological effect of the active pharmaceutical ingredient – excretion into the wastewater treatment plants, which can't take every trace of medicine out, the efficacy of removal is between 10 and 80% so a lot ends up in rivers and oceans.
- Waste – a lot reaches landfill or water.

Key areas to work on would be inhaler prescribing mainly switching metered doses to dry powder inhalers as they don't use hydrofluorocarbons (greenhouse gases). Use of plastic can also be reduced. Antidepressants have a toxic effect on aquatic life. Some of the planned work might lead to a change in direction of some of the policies or processes or principles that we had in NHS Highland previously that may now not be fit for purpose. One example is that the current promotion of generic prescribing may need to change to inform prescribers of the more environmentally friendly choices. One Health Breakthrough Partnership (a collaboration that NHS Highland is in with SEPA, Scottish Water and the University of the Highlands and Islands) has completed some baseline work around the amount of pharmaceuticals in Scottish waters that is being used to guide any future work on which are the priority substances and how do they tackle them etc.

The following comments were made:

- Great presentation. Impressed that the submissions to this meeting have all taken the environmental impact seriously.
- We are the only Health board in NHS Scotland to have the environmental impact question on our Formulary submission.
- Can we add a traffic light system on to TAM with how green a medicine is? This is currently being worked on.
- Packaging is a big issue, how can we influence reduction of this? The Royal Pharmaceutical Society Sustainability Policy includes that work is done with pharmaceutical companies to rationalise packaging and where there is a need for the packaging to make it recyclable.

13. FORMULARY REPORT

It is hoped that a Formulary report on secondary care prescribing will be provided to future meetings along with the current report that is given for primary care prescribing. Alimemazine is being discussed with Dermatology to find out if there is a way to reduce prescribing of it in primary care. There is a Pink One article coming out for midazolam stating that Epistatus is used for seizure control whereas Buccolam is used for palliative care prescribing.

14. SMC ADVICE

Noted.

15. NHS WESTERN ISLES

Nothing to report.

16. ANY OTHER COMPETENT BUSINESS

None put forward.

17. DATE OF NEXT MEETING

Next meeting to take place on Thursday 9 December 2021, 14:00-16:00 via TEAMS.

The following proposed dates for 2022 were agreed:

24 February
28 April
30 June
25 August
27 October
8 December.

Actions agreed at TAM Subgroup meeting

Minute Ref	Meeting Date	Action Point	To be actioned by
Follow up report *Back to minutes*	October 2021	Remove the TAM survey and TAM training video from the follow up report as they now come under the remit of the TAM Project Manager.	**WA**
Fremanezumab (Ajovy) for subcutaneous injection only *Back to minutes*	October 2021	If required, will monitoring be carried out by the specialist?	**PH**
Galcanezumab (Emgality) 120mg galcanezumab injected subcutaneously (SC) *Back to minutes*	October 2021	Erenumab is already on the Formulary for chronic migraines but this is listed under the category 'prophylaxis of episodic migraines'. To clarify with submitter how the monographs should be presented.	**PH**
	October 2021	If required, will monitoring be carried out by the specialist?	**PH**
Methoxyflurane (Penthrox) 99.9% 3ml inhalational vapour, liquid *Back to minutes*	October 2021	Query if use can be extended for primary care and other areas eg BASICS, Mountain Rescue and Community Hospitals.	**PH**
	October 2021	Request cost comparison information between Entonox and Penthrox and circulate to the Group.	**PH**
	October 2021	Request for patient numbers of usage of Entonox. An audit is currently underway, once available the data to be shared with the Group.	**PH**
	October 2021	Are ventilated rooms, annual checks of equipment and registration of Community Pharmacies required for Penthrox?	**PH**
Requesting Echo for TIA/Stroke *Back to minutes*	October 2021	Clarify that this is for Secondary care only.	**PH**
Peri-operative guidelines for adults with and at risk of adrenal insufficiency *Back to minutes*	October 2021	Will this be incorporated into the pre-op assessment?	**PH**
	October 2021	Clarification required within the guidance on when to give additional hydrocortisone (eg not with high-dose inhaled steroids, just for those already on hydrocortisone).	**PH**
	October 2021	Add link to relevant Formulary monograph and include an article in the Pink One.	**PH**

Formulary Minor additions/ deletions/amendments *Back to minutes*	October 2021	Further discussion to take place out with the meeting as to when a submission for a new indication should be made.	**PH/RP**
	October 2021	Shared care protocols to be discussed with GP Subcommittee.	**PH**
Guideline minor amendments *Back to minutes*	October 2021	Heart failure – add MRA to the glossary.	**PH**
	October 2021	Request that there is explanation of CBT programmes and that these new programmes are promoted.	**PH**
	October 2021	To add: Sennosides (previously known as senna)	**PH/JS**