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 February 2025, via Microsoft TEAMS

Present:	Findlay Hickey, Principal Pharmacist (Medicines Management and Prescribing Advice) (acting Chair) Patricia Hannam, Professional Secretary, Formulary Pharmacist Dr Robert Peel, Consultant Nephrologist Wendy Laing, Primary Care Clinical Pharmacist Lauren Stevenson, Pharmacist, Medicines Information Service Dr Jude Watmough, GP Joanne McCoy, MySelf-Management Manager Dr Simon Thompson, Consultant Physician Dr Antonia Reid, GP Dr Sarah Donald, GP Emma King-Venables, Lead AHP, A&B Dr Stephen McCabe, Clinical Director, Primary Care Linda Burgin, Patient Representative
In attendance:	Wendy Anderson, Formulary Assistant Dr Amy Macaskill, Consultant Psychiatrist (for AOCB – CMHT guidance)
Apologies:	Alasdair Lawton, Chair Jenny Munro, AP Physiotherapist Continence and Independent Prescriber Duncan Scott, Consultant Physician

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

Nothing declared.

3. MINUTES OF MEETING HELD ON 5 DECEMBER 2024

Minutes accepted as accurate.

4. ACTIONS FROM PREVIOUS MEETING

ITEM	ACTION POINT	ACTION	STATUS	COMMENTS
Register of interest	An annual Register of Interest form would shortly be sent out to all members to complete and return.	**ALL**	In progress	Form sent to all, still awaiting some completed returns.
Varenicline (generic) 500 microgram, 1mg tablet	What is the place in therapy?	**PH**	Complete	No identified place in therapy all products offered as per suits patient according to pathway
	There are a few warnings for use in psychiatric conditions; can these be highlighted on the formulary monograph.		Complete	

TAM134 Hypertension	What is age cut off for non intensive patients getting blood pressure being checked every 5 years and the benefit of the check being done? What is the consequence of harm if blood pressure check is not carried out? Agreed to change wording to consider for both optimal and consider.	**PH**	Complete	Consider' added
	Noted that there are misalignments regarding referral. Request comments from Cardiology and Renal departments.		Complete	Rephrased to 'via usual pathways'
	Refers to a ASSIGN score but there is also a Q-risk score. There should be alignment between the specialities?		Complete	Assign is the recommended tool to be used in Scotland. Q-risk is not in the hypertension guideline. There is a link to a NICE patient decision aid which has Q-risk. Unable to change this.
	Management in Primary Care; can this be changed to Management as there will be no separate Secondary Care guidance in place.		Complete	
	The flow chart is an adapted version of the NICE flow chart. The question was put to the Subgroup as to whether the guidance retains the locally adapted coloured flow chart or to just link to the NICE guidance. A decision was not made; although it was felt the coloured version was preferable.		Complete	
	Under Initial investigation: If you are doing a serum renin you should also do a serum aldosterone at the same time.		Complete	
	Non-emergency referral; Renal do not use clinical dialogue so remove.		Complete	
	Agreed that the finalised document be sent out to the Subgroup via email for ratification		Complete	Post subgroup ratification of guidance. Accepted. Comments. Still considered to be too wordy, however is in line with NICE guidance. Request to develop guidance on the management of hypertensive crisis in secondary care. In the quick reference guide grade 1 add 'year' to age <40. Check review monitoring timelines. Consider reviewing sooner after some feedback from users.

				The British Hypertension Society home blood pressure diary may have been a useful template to use.
TAM260 Smoking cessation	Champix brand to be removed and information on varenicline updated.	**PH**	Complete	
	Confirmation required on communication pathway back to clinicians with regards to prescribing NRT products and varenicline.		Complete	
	Include link to Nicotine Dependence Formulary monograph.		Complete	
TAM288 Sleep pathway	Noted that the author has not commented back on the responsibilities section which has been rewritten. Agreed to contact the author to say the submitted guidance has been approved by Subgroup and request final comment before publication.	**PH**	Complete	
	Information on bed wetting to be included.		Complete	
	A definite end of treatment review should be included when Paediatric services hand over on transition to adult services.		Complete	
	A Pink One article to be written to emphasise cost implications of melatonin.		Pending	
	To highlight the cost of melatonin liquid, move the costing information higher up in that section.		Complete	
TAM report	Can some of the COVID guidance be merged into Antimicrobial guidance.	**PH**	In progress	A clinical lead has been identified. To make COVID guidance business as usual. To create Infectious Diseases section on TAM.
	Contact Clinical Lead for eHealth, Ken Macdonald for his views on permission to view the contract with Tactuum.		In progress	
	Ask for detail on operational information and bring to Subgroup to identify any gaps that there are concerns about.		On hold	SLA details are not available.

5. FOLLOW UP REPORT

The follow up report was noted.

6. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

6.1. SACT Formulary submissions for noting

Medicine Company	Indication	Status SMC/licence/ formulary	Requestor	Comments
Trametinib	Trametinib for the treatment of low	NCMAG118	Catriona Hoare,	**ACCEPTED**

(Mekinist) film-coated tablets 0.5mg, 2mg Novartis	grade serous ovarian cancer after at least one line of platinum-based chemotherapy.	this off-label use is supported	Cancer Care Pharmacist - Oncology	
Cemiplimab (Libtayo) concentrate for solution for infusion 350mg vial Regeneron UK Ltd	As monotherapy for the treatment of adult patients with recurrent or metastatic cervical cancer and disease progression on or after platinum-based chemotherapy.	SMC2719 accepted for use	Kirsti Mjoseng, Cancer Care Pharmacist - Oncology	**ACCEPTED**
Durvalumab (Imfinzi) concentrate for solution for infusion 50mg/ml AstraZeneca UK Ltd	In combination with etoposide and either carboplatin or cisplatin for the first-line treatment of adults with extensive-stage small cell lung cancer (ES-SCLC).	SMC2734 accepted for use	Kirsti Mjoseng, Cancer Care Pharmacist - Oncology	**ACCEPTED**
Olaparib (Lynparza) film-coated tablets 100mg, 150mg AstraZeneca UK Ltd	Monotherapy for the treatment of adult patients with germline BRCA1/2-mutations, who have HER2−negative locally advanced or metastatic breast cancer (mBC). Patients should have previously been treated with an anthracycline and a taxane in the (neo)adjuvant or metastatic setting unless patients were not suitable for these treatments. Patients with HR+ breast cancer should also have progressed on or after prior endocrine therapy, or be considered unsuitable for endocrine therapy.	SMC2737 accepted for use	Kirsti Mjoseng, Cancer Care Pharmacist - Oncology	**ACCEPTED**
Danicopan (Voydeya) film-coated tablets 50mg, 100mg Alexion Pharmaceuticals	As an add-on to ravulizumab or eculizumab for the treatment of adult patients with paroxysmal nocturnal haemoglobinuria (PNH) who have residual haemolytic anaemia. **SMC restriction:** under the advice of the national PNH service.	SMC2675 accepted for restricted use	Jenna Baxter, Lead Cancer Care Pharmacist - Haematology	**ACCEPTED**
Iptacopan (Fabhalta) capsules 200mg Novartis Pharmaceuticals	As monotherapy in the treatment of adult patients with paroxysmal nocturnal haemoglobinuria (PNH) who have haemolytic anaemia. **SMC restriction:** under the advice of the national PNH service.	SMC2676 accepted for restricted use	Jenna Baxter, Lead Cancer Care Pharmacist - Haematology	**ACCEPTED**

6.2. Non SACT Formulary submissions

6.3. Dalteparin (Fragmin) solution for injection 5,000/0.2mL, 7,500/0.3mL, 10,000/0.4mL, 12,500/0.5mL, 15,000/0.6mL, 18,000/0.72mL, Pfizer Ltd (SMC683/11 – for a different indication)

Submitted by: Kirsten McCulloch, Renal Pharmacist

Indication: Anticoagulation of the extracorporeal circuit during haemodialysis in adult patients.

Comments: Due to shortages with tinzaparin, dalteparin has been used on the ward and has proven to be efficacious. It is now part of established practice and so has been submitted to bring the Formulary in line with current practice. The current guideline will need to be updated in line with this medicine being accepted. Comment that tinzaparin should be used first line as it is licensed for this indication, whereas it is an off-label use for dalteparin. Off-label use will be added to the formulary monograph.

ACCEPTED

Action

7. FORMULARY

7.1. Symptomatic Relief Formulary

- After discussion as to whether oral rehydration salts should be included it was agreed that they should be as the Formulary is based Highland wide and they are used in community settings.
- Add examples of brands for Oral rehydration salts eg Dioralyte.
- Should we be using the terminology senna (which BNF uses) or sennosides?
- Paracetamol: Amalgamate the 1st and 3rd bullet points so doses sit together. Remove 'consider'. Should we change to one tablet or one suppository instead of stipulating dose?

ACCEPTED pending

Action

7.2. Wound Management guidelines and Formulary

- It's a big document that seems busy. Can it be streamlined? Agreed to send mock up with new layout to JW for comment.
- After discussion agreed to remove section on analgesia and replace with link to acute pain guidance due to concern around NSAID use.

ACCEPTED pending

Action

7.3. Compression hosiery formulary: Highland HSCP only

ACCEPTED

8. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS

Noted and approved.

9. FORMULARY REPORT

No new report available.

10. SMC ADVICE

Noted. Of note: the chair of SMC, Scott Muir, and the Chief Pharmacy Adviser will be attending the next ADTC meeting due to be held on 23 April. The purpose being to engage with health boards and to understand how we use their processes and how we interact with SMC. If the Subgroup has any comments/questions please forward them to PH to raise at the meeting.

11. *the* PINK ONE

This is a publication aimed at prescribers with is edited by the Formulary Team. Articles are provided by clinicians throughout NHS Highland, and we are seeking ways to engage with the various sectors. Winter 2024/2025 edition was shared for information with a request for articles to be sent to PH.

12. NEW TAM GUIDANCE FOR APPROVAL

12.1.TAM543 Fluid Balance

- Subgroup members found that the fluid calculator did not stand up to their own 'stress testing' of pushing the calculator boundaries, ie the results were not appropriate for 'not very unusual' scenarios. Can this be investigated further and also fed back to the national tool/guideline developers as a concern to be looked into ASAP?
- It was felt that using such a tool had an element of 'dumbing down' of guidance for clinicians who would not then have the opportunity to build up the practical experience and knowledge base in identifying the patient's risks/parameters and choosing an appropriate product. It would be preferable to have guidance in place that gave the clinician the information they need for them to make a judgement rather than a tool that gave you the answer without the workings out. Comment was made that learned tool responses would be made (ie last patients inputs gave answer X so this time it will also be answer X) rather than informed responses.
- A separate issue is that the choice of fluids are not on the Highland Formulary. This is historical and PH will follow this up via formulary processes with David Hepburn in the first instance.
- The choice of fluid is in question; eg a comment raised was whether Maintelyte has the correct composition for the purpose needed on the ward. Also that the calculator would allow, for example, a 500mL bag of potassium, which is not currently stocked at Raigmore.
- Noted that the national guidance states: Individual NHS Boards should confirm consistency with local procedures and governance processes eg Area Drug and Therapeutics Committee

approval.

REJECTED

Action

12.2. TAM663 Vascular access in adult patients

ACCEPTED

12.3. TAM665 Food Allergy Service

ACCEPTED

12.4. TAM674 Hyperkalaemia: Primary Care

ACCEPTED

12.5. TAM675 Parenteral nutrition

ACCEPTED

12.6. TAM676 Lyme disease

- Seem to be slight differences about when to do serology testing, is this intentional?
- To query the term 'always' in the statement: Lyme serology is always positive in Lyme arthritis.

ACCEPTED pending

Action

13. GUIDELINE MAJOR AMENDMENTS

13.1. TAM651 Bell's Palsy

ACCEPTED

13.2. TAM298 Vitamin D Deficiency

- Why is this local guidance in place when there is good NICE guidance available? Which parts of the national guidance do the authors feel are not adequate?
- The guideline has been put in place to try and support the reduction of referrals for testing. Subgroup suggested that the best way to tackle this is to have clearer information on testing available. GP Subgroup members felt that the guidance wasn't needed but that testing information should be made available on ICE.

REJECTED

Action

13.3. TAM678 Pathway B: Metabolic dysfunction associated steatotic liver disease (MASLD)

- The current guidance has been split into two; one for primary care and one for secondary care.

Primary Care

- Noted that this guidance had been discussed at GP subcommittee.
- There was confusion as to what the following statement under 'Suggested liver screen' meant: '**In NHSH, requests for ELF, ceruloplasmin and alpha-1-antitrypsin are not currently part of the standard primary care liver blood screen. They may be requested as required by secondary care at the point of vetting and triage referrals**'. This was and could be misunderstood as meaning that GPs *should not* screen for these two tests, rather that they are not available as the standard liver screen set. Please can this be reworded? Eg: **In NHSH, the standard primary care liver blood screen for ELF does not include ceruloplasmin and alpha-1-antitrypsin. These may be requested as required at the point of vetting and triage referrals.**'
- Suggest that the 'ICE' order set be amended to include two different liver screening sets one for under 50's and one for over 50's and the ceruloplasmin and alpha-1-antitrypsin screen is added to the relevant one.

ACCEPTED pending

Action

TAM672 Pathway B: Metabolic dysfunction associated steatotic liver disease (MASLD) s*econdary Care*

ACCEPTED

13.4. TAM459 Asthma (Adults) *(this was discussed after point 15 TAM report)*

- This guideline was submitted late to Subgroup however due to its perceived urgency the ask of Subgroup is whether this guidance can be discussed today or whether it should await submission to the April TAMSG. TAMSG agreed that there is need for the updated guidance in Primary Care now and the updated guidance should not be delayed. It was accepted that there may be amendments needed to it and also that paediatric guidance would follow, hopefully in April.
- There is now a national document available which includes a major change in clinical practice,

particularly for primary care. The main change is that SABA inhalers as monotherapy are no longer to be used first line for patients and are no longer recommended for new patients.

- There was discussion about feNO and eosinophil testing and at what stage of the pathway that would be done and do all practices have access to this.
- The respiratory team are aware of the need for an implementation plan, and Public Health are able to provide support in this and in particular will undertake data collection to identify patients who are using too many SABA inhalers.
- How will this change in practice be disseminated to practices? Can this be done via prescribing advisors? Request that Thomas Ross or Jill Winchester are directly involved in discussion regarding this.
- This will not be a rapid switchover of existing patients but more a managed, controlled one with new patients, patients whose asthma is not controlled or who are identified via the data collection.
- Patient information to be requested as a lot of patients are interested in the 'green' aspect of switching.
- An educational day in the general Grand Round for secondary care clinicians and education for GP clusters was planned. A video will be developed by the respiratory team. Are respiratory planning any educational days aimed at practice nurses?
- Pink One article to be written.
- Agreed that a pop up should be added to Scriptswitch to flag up change in practice with the wording developed in liaison with the respiratory team.

ACCEPTED pending

Action

14. GUIDELINE AMENDMENTS
Noted and approved.

SM left the meeting.

15. TAM REPORT
Report noted with particular mention made to: • Ongoing work to reduce out of date guidance is being made. • A TAM flash report was included in the most recent edition of the Pink One. • Discussion with Tactuum is taking place to try and have better linkage between guidelines and the Formulary, with the possibility of the Formulary having a database in the background for improved functionality. • Departmental guideline reports have been sent out. • TAM staffing – the substantive Project Support Manager is returning from maternity leave but has reduced working hours to a 3 day week. The other 2 days gave been put out to advert with a closing date of 9 March. PH still to meet with AL regarding additional TAM staffing. PH has had discussion with the Endowments Team and is now exploring different avenues, progress/information on this will be reported to a future meeting when available. • Regarding outages/site going down, the software company have been working on this and have separated out the app from the website to try and improve functionality.

RP left the meeting.

16. ENVIRONMENT
The asthma guidance will support environmental prescribing or DPIs.

17. NHS WESTERN ISLES
Nothing to report.

18. ANY OTHER COMPETENT BUSINESS
Community Mental Health Team guidance This updated guidance was received after the agenda and papers had been distributed but was noted as an urgent update and therefore tabled.

It has been updated in line with the Care Mental Health Quality Standards, September 2023. The referral criteria has been clarified and the referral process has been made clearer. It has gone through GP Subcommittee, the Primary Care Mental Health Interface meeting, the Mental Health and Learning and Development Senior Management Team, the Mental Health Learning Development Clinical Governance Group and the Adult Mental Health Specialism Group.

Noted that as a large amount of GP referrals are rejected by the CMHT. A section specifically about referrals that have been rejected had been included in this update but was then removed after feedback from GP Subcommittee. An audit was carried out regarding returned referrals and GP referral tips have been developed and included to try and improve this. Going forward returned referrals will be signed by the lead professional for that day rather than from a generic team as per previous. This was welcomed by the Subgroup.

Subgroup requested time to review the guidance before ratification, but agreed that this could be done prior to the April TAMSG. Guidance to be emailed out to all Subgroup members, with any comments to be returned by Friday 7 March.
Action

19. DATE OF NEXT MEETING
Next meeting to take place on Thursday 24 April 2025, 14:00-16:30 via TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Action Point	Action by
Dalteparin (Fragmin) solution for injection 5,000/0.2mL, 7,500/0.3mL, 10,000/0.4mL, 12,500/0.5mL, 15,000/0.6mL, 18,000/0.72mL, Pfizer Ltd (SMC683/11 – for a different indication) *Back to minutes*	Anticoagulation of the extracorporeal circuit during haemodialysis in adult patients (Guidelines) | Right Decisions (scot.nhs.uk) to be updated in line with this submission.	**PH**
Symptomatic Relief Formulary *Back to minutes*	• Add examples of brands for Oral rehydration salts eg Dioralyte. • Should we be using the terminology senna (which BNF uses) or sennosides? • Paracetamol: Amalgamate the 1st and 3rd bullet points so doses sit together. Remove 'consider'. Should we change to one tablet or one suppository instead of stipulating dose?	**PH**
Wound Management guidelines and Formulary *Back to minutes*	• Can it be streamlined? Agreed to send mock up with new layout to JW for comment. • After discussion agreed to remove section on analgesia and replace with link to acute pain guidance due to concern around NSAID use.	**PH**
TAM543 Fluid Balance *Back to minutes*	• Subgroup members found that the fluid calculator did not stand up to their own 'stress testing' of pushing the calculator boundaries, ie the results were not appropriate for 'not very unusual' scenarios. Can this be investigated further and also fed back to the national tool/guideline developers as a concern to be looked into ASAP? • It was felt that using such a tool had an element of 'dumbing down' of guidance for clinicians who would not then have the opportunity to build up the practical experience and knowledge base in identifying the patient's risks/parameters and choosing an appropriate product. It would be preferable to have guidance in place that gave the clinician the information they need for them to make a judgement rather than a tool that gave you the	**PH**

	answer without the workings out. Comment was made that learned tool responses would be made (ie last patients inputs gave answer X so this time it will also be answer X) rather than informed responses. • A separate issue is that the choice of fluids are not on the Highland Formulary. This is historical and PH will follow this up via formulary processes with David Hepburn in the first instance. • The choice of fluid is in question; eg a comment raised was whether Maintelyte has the correct composition for the purpose needed on the ward. Also that the calculator would allow, for example, a 500mL bag of potassium, which is not currently stocked at Raigmore.	
TAM676 Lyme disease *Back to minutes*	• Seem to be slight differences about when to do serology testing, is this intentional? • To query the term 'always' in the statement: Lyme serology is always positive in Lyme arthritis.	**PH**
TAM298 Vitamin D Deficiency *Back to minutes*	• Why is this local guidance in place when there is good NICE guidance available? Which parts of the national guidance do the authors feel are not adequate? • Subgroup members felt that the guidance wasn't needed but that testing information should be made available on ICE.	**PH**
TAM672 Pathway B: Metabolic dysfunction associated steatotic liver disease (MASLD) – primary care *Back to minutes*	• There was confusion as to what the following statement under 'Suggested liver screen' meant: 'In NHSH, requests for ELF, ceruloplasmin and alpha-1-antitrypsin are not currently part of the standard primary care liver blood screen. They may be requested as required by secondary care at the point of vetting and triage referrals'. This was and could be misunderstood as meaning that GPs should not screen for these two tests, rather that they are not available as the standard liver screen set. Please can this be reworded? Eg: In NHSH, the standard primary care liver blood screen for ELF does not include ceruloplasmin and alpha-1-antitrypsin. These may be requested as required at the point of vetting and triage referrals.' • Suggest that the 'ICE' order set be amended to include two different liver screening sets one for under 50's and one for over 50's and the ceruloplasmin and alpha-1-antitrypsin screen is added to the relevant one.	**PH**
TAM459 Asthma (Adults) *Back to minutes*	• There was discussion about feNO and eosinophil testing and at what stage of the pathway that would be done and do all practices have access to this. • How will this change in practice be disseminated to practices? Can this be done via prescribing advisors? Request that Thomas Ross or Jill Winchester are directly involved in discussion regarding this. • Patient information to be requested as a lot of patients are interested in the 'green' aspect of switching. • Are respiratory planning any educational days aimed at practice nurses? • Pink One article to be written.	**PH**

	• Agreed that a pop up should be added to Scriptswitch to flag up change in practice with the wording developed in liaison with the respiratory team.	
AOCB – *Community Mental Health Team guidance* *Back to minutes*	Guidance to be emailed out to all Subgroup members, with any comments to be returned by Friday 7 March.	**ALL**