1. WELCOME AND APOLOGIES
The Chair welcomed the group and introductions were made.

2. MINUTES OF MEETING ON 31 AUGUST 2018
Accepted as accurate.

3. DECLARATIONS OF INTEREST
No interests were declared.

4. FOLLOW-UP REPORT ON ACTIONS AGREED ON 31 AUGUST 2018 - tabled

Outstanding actions:

Therapeutic drug monitoring in primary care
Due to staffing it is difficult to find someone to delegate to at present; to consider a MSc student. FH found a template in Doncaster as a starting point, reported that there is nothing usable at national level; the Specialist Pharmaceutical Service (SPS) document being very ‘clunky’.
Action FH: to identify an MSc student.
Action PH: while the issue is being resolved TAM is to link to the SPS document.

Indigestion algorithm
Action PH: To follow this up with Dr Potts’ secretary.

Addition of oncology medicines to Vision formulary
Oncology medication is not routinely marked as formulary on Vision. Therefore do not add oncology submissions to the Vision Formulary unless requested to do so.
No action.

Tracking oncology medicines
There is no formal process in place to track medicine usage.
Chemocare will store data on all drugs prescribed, all diagnosis and all patients, however it is
designed as a prescribing system not for data extraction.

**Action OM:** TAM subgroup to decide if medicine usage following submissions are to be tracked.

**Develop TAM processes and Update remit and Terms of Reference**

**Action PH:** Ongoing

**Naming brands for hospital contract items**

**Action PH:** Ongoing

**Prescribing cost containment**

It was highlighted that there would need to be analogous signatories for primary care as had been
agreed in secondary care. Suggestions: 1. District medical lead, 2. District or Divisional Manager, 3.
Finance.

**Action PH:** To seek agreed signatory list for primary care.

**Set up encrypted email**

Not required at present as non-NHS members have agreed to receive paper copies at present.
No action.

### 5. CONSIDER FOR APPROVAL ADDITIONS TO FORMULARY

#### Dermamist® emollient spray

**Submitted by:** Dr Rashmi Srivastava, locum consultant Obstetrics and Gynaecology

**Indication:** Within SPC. Specifically: Post-operative - vulval surgery, for vulval eczema and chronic vulval
conditions.

**SMC:** n/a

**Comments:** No equivalent product on Formulary. Mist would reduce infection. Already in use, SC is keen to
support as there is no alternative. Amount required per patient not stated.

**ACCEPTED**

#### Dupilumab (Dupixent®)

**Submitted by:** Dr Louise Macfarlane, Consultant Dermatologist

**Indication:** As per SMC.

**SMC:** SMC2011 PAS and PACE

**Comments:** Significant cost to service. Prescribing Cost Containment process to be discussed at monthly
dermatology meeting (end of Nov 2018). Concerns were raised about the impact of this on primary care;
further information needed.

**ACCEPTED pending:**
- Approval via the cost-containment process
- Confirmation that a shared care protocol is not needed or, if needed, that one is developed.

#### Adrenaline/epinephrine (Emerade®)

**Submitted by:** Mairi Dunbar, Lead Pharmacist, Paediatrics, Obstetrics & Gynaecology

**Indication:** As per SPC.

**SMC:** n/a

**Comments:** There is a current shortage of Epipen®. Emerade® is to be used second-line to Epipen® when
there is a shortage and first-line when 500microgram strength is needed. Paediatric epilepsy nurses are
trained in the use of each device and can provide training on each. It is understood that there is to be a review
looking at which preparation should be used in the long term.

**ACCEPTED**

#### Beclometasone dipropionate/formoterol fumarate dehydrate/glycopyrronium inhaler (Trimbow®)

**Submitted by:** Catriona Wheelan, Lead Pharmacist Respiratory & Gastroenterology

**Indication:** as per SMC advice.

**SMC:** 1274/17
Comments:
FH was not keen to accept either Trimbow® or Trelegy® Ellipta®. The guidelines are past their review date and there is a need for clarity about when to use triple therapy and where they fit in with GOLD guidance. Recommends waiting until NICE guidelines on COPD are published (December). RP added that the benefit is marginal in some patients therefore we need to be clear on when to use it. PH expects the respiratory review group to produce some guidance for January; FH suggested waiting for the guidance then looking at the submissions.
REJECTED pending updated guidance

Fluticasone furoate, umeclidinium, vilanterol (as trifenatate) inhalation powder (Trelegy® Ellipta®)
Submitted by: Catriona Wheelan, Lead Pharmacist Respiratory & Gastroenterology
Indication: As per SMC.
SMC: 1303/18
Comments: Comments as for Trimbow®.
REJECTED pending updated guidance

Mycophenolic acid as mycophenolate sodium 360mg tablets (Ceptava®)
Submitted by: Dr Robert Peel, Consultant Nephrologist
Indication: As per SPC.
SMC: n/a
Comments: To replace Myfortic®. Made by the same company as Myfortic®, but cheaper. RP will switch patients. The big saving will be in primary care. Agreed that similar switches are to be submitted as minor amendments.
ACCEPTED

6. FOLLOW UP ON GUIDANCE FROM AUGUST 2018

Lyme disease – presented by AM
Requested action points addressed. Led to notice of error in NICE guidance on lyme carditis. AM explained that the guidance cannot be simplified further from the NICE guidance without losing clarity. Noted that cefuroxime is no longer part of NICE guidance.
It was agreed not to link to the NICE guidance throughout but to write out the guidance as it was felt that users would prefer to read presented information rather than follow links.
ACCEPTED pending action
Action: Add note about Lyme rash at top of section. AM

Pre-hospital & community hospital use of antibiotics for treatment of sepsis in adults – presented by AM
Requested action points addressed.
AMT are trying to reduce unnecessary exposure to 3rd generation cephalosporins and the risk of Clostridium difficile (C diff) infection. Discussion about the C diff risk with the administration of the more common and broad-spectrum antibiotics versus administration error risk with less frequently used but narrow-spectrum antibiotics.
It was agreed to swap ‘Preferred Option’ with ‘Alternative Option’ section at the top; with concerns that if not done it would be an organisational risk.
ACCEPTED pending action
Action: Amend layout: ‘Alternative’ section at top. RK/PH
Add chloramphenicol IV to the OOH formulary RK

Hearing problems in adults pathway
Requested action points addressed.
Since the papers were sent out, the referral information has been simplified to one section.
It was agreed that the referrals section should come before the management section.
ACCEPTED pending action
Action: Put referral section before management section. RK/PH
Rename ‘Management’ to indicate which parts are to be done by GP and which by Audiology department.
Put ‘adults with suspected….disability’ under ‘referral to Audiology’
Add screening questionnaire pdf
### Management of Warfarin and Direct-Acting Oral Anticoagulants (DOACs) in Adult Patients Undergoing Surgery

The document was significantly reworked according to the requested action points however there were still concerns regarding its content.

Dose in renal failure has now been agreed.

It was agreed that documents need to come to the Subgroup in a more finalised format.

#### REJECTED

**Action:**  
Add LMWH abbreviation  
Remove ‘A reversal agent....not yet available.’

Remove ‘Prothrombin ...is probably unhelpful... perioperatively.’

In the tables at Day-1 add Pre-op information re INR and move ‘under 50kg’ to top of list

Add Cockcroft Gault constant to calculation

Add gentamicin and vancomycin calculator link

Consider SMC table for Beriplex dosing guidance.

PH and FH to go through guidance on TAM and then meet with Dr Howes

#### PSA (prostate-specific antigen) follow-up monitoring — presented by BC

Requested action points addressed.

BC stated that the pathway came about from issues around who would carry out testing and is therefore useful for both primary and secondary care clinicians. Also that while there is more information than generally needed, this information is useful to locums in secondary care. The pathway has had primary and secondary care input.

**ACCEPTED**

**Action:**  
Upload to TAM

#### First seizure’ patient information leaflet

Requested action points addressed.

AR had seen in a different version of the leaflet from which resulted from a SEA (Significant Event Analysis). It had further advice regarding a second seizure. This would need to be the same as on this leaflet therefore further information is needed as to whether the patient should phone 101 or GP etc.

**ACCEPTED pending action.**

**Action:**  
To clarify what information is needed regarding what to do if there is a 2nd seizure  
Add ‘(999)’ to ‘Call an ambulance (999) if:’

#### 7. UPDATED AND NEW HIGHLAND FORMULARY SECTIONS AND GUIDANCE

**a) NHS Highland policy for the treatment of infective endocarditis**

**ACCEPTED**

**Action:**  
Upload to TAM  
Upload to Antimicrobial guidance app

**b) Gastro-intestinal tract infections**

**Comments:**

There was a request to define ‘broad-spectrum penicillins’ as co-amoxiclav and ciprofloxacin.

The Highland Infection Control Policy has been superseded by Health Protection Scotland guidance.

**ACCEPTED pending action**

**Action:**  
To name the broad-spectrum penicillins and quinolone eg, co-amoxiclav and ciprofloxacin.

Change e. Coli 0157 to O157

Upload to TAM

Upload to antimicrobial app

**c) Bone and joint infections**

**ACCEPTED**

**Action:**  
Upload to TAM  
Upload to Antimicrobial guidance app
**d) Diabetic foot infections**

Comments:
There was discussion about the meaning of ‘early vascular assessment’ and whether this would have been carried out beforehand. Agreed to remove ‘early’

**ACCEPTED subject to amendment**

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<thead>
<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Remove ‘early’ as above</td>
<td>RK</td>
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<tr>
<td>Upload to TAM</td>
<td>RK</td>
</tr>
<tr>
<td>Upload to antimicrobial app</td>
<td>AM</td>
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**e) Vancomycin prescription form**

As papers had not been submitted it was agreed that this would be reviewed at the next Subgroup meeting.

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**8. RECOMMENDATIONS FOR MINOR AMENDMENTS TO HIGHLAND FORMULARY**

PH stated that where possible the amendments were direct quotes from the original source such as the BNF or MHRA (Medicines Healthcare products Regulatory Agency) and that the relevant link to the full source would be provided on TAM.

Comments:
LR asked whether the MHRA guidance on fentanyl patches mentioned heat, because showers, hot water bottles, etc. can increase side-effects and that awareness should also be raised with regard to warming blankets used by anaesthetists. It was agreed that a Pink One article should be written to raise awareness.

**Action:**
- Upload to TAM
- MHRA to be stated in full
- Pink One article on heat and fentanyl patches.

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**9. FORMULARY DECISIONS ON RECENT SMC ADVICE**

The report outlined Scottish Medicines Consortium (SMC) advice to date and whether any of the medicines had been accepted as submissions to the Formulary.

RP clarified that ‘not recommended for use in Scotland’ meant not recommended by SMC. The layout of the report is standardised throughout Scotland.

**Action:**
- Upload on intranet and internet

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**10. SINGLE NATIONAL FORMULARY**

The Chair had nothing new to report. He is hoping to go to Edinburgh to talk to the national team and to get a perspective of his concerns about industry involvement.

**Action:**
- Report back on meeting with SNF team

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**11. TAM report**

Funding for a permanent TAM Project Manager post has been secured and was submitted to the vacancy process on 12th October.

A bid to the Value Improvement Fund for development of the patient information section on TAM was rejected but PH can try again in April. JW offered to assist with this. The Chair suggested applying to the Endowment Fund. AR had information about other NHS websites which are producing patient information practice websites and suggested that this could be used.

LR was introduced as a new member of the Subgroup as an independent nurse prescriber in secondary care. On DS’s behalf PH proposed that DS acts as clinical Lead for TAM. There is no extra time commitment for this role. The Subgroup approved this.

PH reported that the Search function on TAM, which has been broken since February, has now been fixed by Tactuum. Work is now required by the local TAM team to put it into effect.

**Action:**
- Work on TAM search function
- VIF to be reapplied for in April
- To see if the Endowment Fund can support the development of the patient information on TAM
- Pass information re NHS Inform patient information practice website development to PH

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**12. NHS Western Isles**

The following link has been agreed between NHS Western Isles (WI) and the NHS Highland TAM subgroup.

- There will be a seat available for a NHS WI representative (currently Dawn Tiernan) when required.
- Agendas and papers will be set to this representative for distribution as appropriate (in particular with
Dr David Rigby) and for comment.

<table>
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<tr>
<th>13. AOCB</th>
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<tbody>
<tr>
<td>The Pink One is now available via TAM.</td>
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<td>It was agreed that the national point-of-care resource that TAM should link to is ‘UpToDate’.</td>
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<td><strong>Action:</strong> Link to UpToDate on TAM <strong>PH</strong></td>
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<tr>
<th>14. MEETING DATES</th>
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<tr>
<td>22 January</td>
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<tr>
<td>19 March</td>
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<td>21 May</td>
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<td>20 August</td>
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<td>22 October</td>
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<td>All meetings are at 12:00-14:00, Meeting Room 1, Birnie Centre, Raigmore Hospital Campus. VC is available. You are welcome to bring lunch/tea/coffee with you.</td>
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