Northern Treatment Advisory Group

Minutes of meeting held on the 7th June 2022, 9-11.30am

Virtual Online Meeting via Microsoft Teams

Present:

- Ian Davidson (ID) Medical Director, County Durham CCG & Chair of NTAG.
- Gavin Mankin (PGM) Principal Pharmacist – Medicines Management, RDTC (professional secretary)
- Robert Lapham (RL) Formulary Pharmacist, South Tyneside & Sunderland NHS Foundation Trust.
- Helena Gregory (EL) Medicines Optimisation Pharmacist and Clinical Quality Team Lead North Cumbria CCG
- Toks Sangowawa (TS) Clinical Advisor/Locum Consultant in Public Health, South Tyneside MBC
- Siobhan Brown (SB), Chief Operating Officer, Northumberland CCG.
- Matthew Lowery (ML) Formulary Pharmacist, Newcastle upon Tyne NHS Foundation Trust.
- Matthew Grove (MG) Consultant Rheumatologist, Northumbria Healthcare NHS Foundation Trust.
- Andrew Lloyd (AL) Consultant Anaesthetist and Chair of South Tees D&T, The James Cook University Hospital (JCUH).
- Sarrah Seldon (SS) Senior Medicines Optimisation Pharmacist, Sunderland CCG.
- Ewan Maule (EM) Interim Lead Pharmacist, NENC ICS
- Jill McGrath (JM) Head of Finance, Newcastle Gateshead CCG
- David Campbell (DC) Chief Pharmacist, Northumbria Healthcare NHS Foundation Trust.

In Attendance:

- Dan Newsome (DN) Principal Pharmacist – Medicines Management, RDTC
- Barry Hogan – RDTC Admin Team – sharing papers on the screen.
- Nancy Kane – RDTC – presenting item 3

Apologies were received from: Joe Corrigan, Jim Welch, Claire Sands, Colin Bradshaw

NTAG noted that Ian Davidson the current NTAG chair is stepping down as Medical Director of County Durham CCG from the end of June 2022 so this will be his last NTAG meeting as chair. The APC wished to express their thanks and gratitude to Ian for all his support and hard work on behalf of the NTAG since its creation. The new interim chair of NTAG will be Ewan Maule.

The meeting was quorate.

No declarations were received prior to the meeting on receipt of the agenda and when the Chair invited any declarations of interest to be made none were declared.

1) Draft Minutes February 2022 Meeting

The group approved the February 2022 minutes with no changes.

ACTION: Secretary to publish February 2022 minutes on the NTAG website.

2) Matters Arising

- Review of NTAG recommendation on Sodium oxybate (Xyrem®) in the management of narcolepsy with cataplexy in adult patients in light of the RMOC position statement – still awaiting RMOC statement on Pitolisant before progressing as may change place in therapy and costings now generic Sodium oxybate available. Chased up with RMOC Secretariat in January and May 2022.
- Review of NTAG recommendations relating to the eye – still awaiting feedback from NE Retina Group as to which recommendations require review. Not progressed due to other NTAG priorities.

3) Appraisal: Budesonide for Maintenance Treatment of Eosinophilic Oesophagitis

The agenda item was introduced by the secretary. It was agreed at the February 2022 NTAG meeting to add to the workplan as has a NICE TA for remission but not for maintenance treatment for which it is also licensed.

No formulary application has yet been received by County Durham & Tees Valley APC, North of Tyne APC or South Tyneside & Sunderland APC. Currently it is a RED drug on local formularies as per NICE TA for up to 12-week treatment course.

Product license states: A maintenance dose of 1 mg budesonide twice daily is recommended for patients with a long-standing disease history and/or high extent of oesophageal inflammation in their acute disease state. The duration of maintenance therapy is determined by the discretion of the treating gastroenterologist depending on severity of symptoms and response.

NTAG reviewed the RDTC Medicines in Practice publication which summaries the clinical evidence supporting Budesonide for Maintenance Treatment of Eosinophilic Oesophagitis.

It was noted that it is a CCG/ICS commissioned tariff included drug which after the initiation and completion of the initial remission treatment course could be suitable for continuation in primary care.

NTAG discussed and agreed to recommend budesonide orodispersible (Jorveza®) for the maintenance treatment of eosinophilic oesophagitis for patients with a long-standing disease history and/or high extent of oesophageal inflammation in their acute disease state. The duration of maintenance therapy is determined by the discretion of the treating gastroenterologist depending on severity of symptoms and response. The group recommends that budesonide orodispersible for maintenance treatment of eosinophilic oesophagitis should only be initiated by specialists but may be suitable for continuation of therapy in primary care. Budesonide orodispersible tablets should be used in line with NICE guidance for treatment of patients with confirmed eosinophilic oesophagitis.

ACTION: Secretary to draft an NTAG recommendation as above

4) NTAG Position Statement on Biosimilars

It was agreed at the February 2022 NTAG meeting to issue a recommendation supporting the use of biosimilars in general (including biologics and insulin) rather than considering each individual biosimilar insulin as they are marketed.

A draft NTAG Position Statement on Biosimilars was presented to and approved by the group subject to addition of adding a sentence on managing the risks around switching if the patient currently still has a supply of the originator product.

ACTION: Secretary to publish final recommendation on NTAG website.

5) Impact of National DOAC Procurement on DOAC Choice for Atrial Fibrillation in NENC

In January 2022, NHS England published an operational note on commissioning recommendations following a national procurement for DOACs. This document advised clinicians to prescribe edoxaban as first line DOAC therapy.

The GP contract IIF indicators were announced two months after NHS England entered into a national procurement agreement with several manufacturers – including those of edoxaban – with the aim that this would allow more patients to be diagnosed and treated. However, some PCN clinical directors have noted that although the lower thresholds are easier to meet from what was proposed initially, there will still be an additional workload to shift patients. And others expressed concerns around the IIF indicator incentivising the use of a particular drug based on cost – although this is allowed under NICE guidance.

There have been differing views across the region on which DOAC (apixaban or edoxaban) should be used in preference. A working group was set up with NENC Cardiac Network to get agreement on a regional position across both primary and secondary care, and to produce a decision aid to support clinicians in choosing the most appropriate DOAC for atrial fibrillation for their particular patient.

A review of all the clinical evidence supports the position that there is no one DOAC suitable for all patients. In terms of NICE all the DOACs have Technology Appraisals which approve them all as options and do not put one DOAC ahead of any other. Current NICE Atrial Fibrillation guidance does not indicate use of any particular DOAC. There are currently no head-to-head RCTs that directly compare DOACs against each other. Network meta-analyses (NMAs) and observational studies using mainly RCTs for each DOAC and various methodologies have, however, been published. Whilst these do have limitations, they can help to provide clarity on how DOACs perform in comparison to each other which can aid clinical decision making. In patients with non-valvular AF (NVAF), it is acknowledged that a ‘one drug fits all’ approach does not apply

There is concern that as the patents for the other DOACs expire any cost efficiencies achieved now from following the recommendations outlined nationally would be eroded. It was expected that the DOACs that are currently prescribed for more than 95% of patients would remain patent protected until at least 2026. However, a generic version of apixaban has just been launched but it is currently the same price as the branded product. The generic was launched as the patent for apixaban has been ruled to be invalid in a recent court case, but this is likely to be subject to appeal, so it is unclear if and when the price of generic apixaban will fall and it will remain available.

It was also noted that NHSE are currently drafting a document on the use of edoxaban and DOACs to support their operational note on commissioning recommendations for national procurement for DOACs. This is likely to be pro-edoxaban and therefore is unlikely to gain consensus for regional use from the NENC Cardiac Network.

After much discussion and consideration of all the evidence the working group propose the following position on choice of DOAC for Atrial Fibrillation in the NENC:

In January 2022, NHS England published an operational note on commissioning recommendations for national procurement for DOACs. Based on a newly negotiated price framework, this document encouraged clinicians to prescribe edoxaban as first line DOAC therapy to realise financial savings. It recognised that clinicians may use an alternative DOAC (Dabigatran, Rivaroxaban, Apixaban) when the alternative is felt to have a clinical advantage over Edoxaban (please see notes below for a local consensus on potential factors to consider). Local consensus does not encourage a strategy of switching DOAC therapy for patients established on non-Edoxaban DOAC therapy to Edoxaban, other than for clinical indications. Converting patients from vitamin K antagonists to DOAC should be encouraged if clinically appropriate and choice of DOAC should be in line with other patients receiving a DOAC prescription for the first time

NTAG discussed the financial impact of the national procurement framework for the NENC. It noted that all CCGs in the NENC have signed up to the rebates available under the NHSE National Procurement Deal for DOACs, so the NENC will benefit to some extent. It also noted that:

- Doing nothing should decrease spend on DOACs for AF but this does not account for any switches from warfarin or growth in new patients starting DOACs for AF.
- Switching patients from warfarin to DOACs may increase spend but this will be offset to some extent by fall in price of some DOACs under NHSE Procurement deal.
- Starting newly diagnosed AF patients on edoxaban and switching warfarin patients to edoxaban (if edoxaban the most clinically appropriate DOAC for the patient in question) is likely to be the most cost-effective way of managing DOAC spend.
- NENC PCNs can only achieve IIF indicator CVD15 thresholds if they actively switch patients on other DOACs to edoxaban. They cannot achieve even the lower threshold target by starting new patients on edoxaban or switching from warfarin alone.

The draft NENC decision aid to support clinicians in choosing the most appropriate DOAC for atrial fibrillation for their particular patient was presented to and discussed by NTAG.

NTAG approved the position statement and decision aid produced by the working group subject to clarifications in the row regarding patients with a history of dyspepsia and the use of a PPI.

NTAG reached this decision because:

- **It felt that the position statement and decision aid produced by the working group has struck a good balance between use of the best value agents and the evidence base for clinical efficacy/safety. Further amendments could risk the regional consensus and support from the NENC Cardiac Network.**
- **Concerns that edoxaban may not be most cost-effective choice in the medium to long-term, so a cautious approach to switching existing patients on DOAC to edoxaban was needed.**
- **NICE and a review of all the clinical evidence supports the position that there is no one DOAC suitable for all patients.**
- **No enthusiasm for switching stable patients on DOACs to another DOAC except on clinical grounds.**

Finally, it was noted that some PCNs may still wish to switch patients to achieve the IIF indicators, and whilst the decision aid does not encourage it does allow for switching. Rather the decision aid suggests when one DOAC may be more appropriate in specified clinical situations.

ACTION: Secretary to finalise decision aid with NENC Cardiac Network and published on website plus circulate to APCs for local adoption/implementation.

6) Review of Current NTAG Recommendation for Flash Glucose Monitoring Following Updated NICE Guidance

NTAG discussed extending the NTAG criteria to reflect the latest NICE recommendations published on 31.3.2022 which address glucose monitoring in both adults and children with type 1 or type 2 diabetes.

NICE now recommends real time continuous glucose monitoring (rtCGM) or Flash Glucose Monitoring (intermittently scanned CGM/isCGM) as an option for all adults with type 1 diabetes in an expansion of the previous NHSE criteria for Flash Glucose Monitoring and the current NTAG criteria from Feb 2022. There is also a widened recommendation from NICE as part of NG28 which states that use of isCGM is an option in some Type 2 diabetes adult patients on multiple daily insulin injections who meet certain criteria including recurrent hypoglycaemia, impaired awareness of hypoglycaemia, a disability which prevents self-monitoring or those who would measure blood glucose very frequently. Finally there have been changes to NICE guidance around the use of rtCGM and isCGM in children and young people with diabetes.

It was noted that the NENC Value Based Commissioning (VBC) Policy was updated in April 2022 to allow use of rtCGM for patients with type 1 diabetes meeting latest NICE criteria.

In terms of cost impact:

- All costings are estimates based on best information available at this time.
- Most eligible adult type 1 diabetes patients are already receiving Flash Glucose in the NENC so a relatively small increase in cost is expected.
- A large proportion of children in NENC with type 1 diabetes are already receiving Flash, therefore the cost impact here is also likely to be relatively small in terms of Flash.
- The biggest cost impact from Flash Glucose is likely to come from extending use to adult Type 2 diabetes population (NICE estimate uptake in this population will increase from 5% currently to 70% by year 5).
- No changes in use for pregnancy expected are expected
- Other cost implications exist with regard to the increased use of rtCGM for adults and children, however these are outside the scope of NTAG and have already been approved in line with NICE by the updated VBC policy.

A draft updated NTAG recommendation on Flash Glucose Monitoring to mirror the latest guidance from NICE published in March 2022, which includes both adults and children with type 1 or type 2 diabetes was presented to and approved by NTAG.

NTAG also discussed and agreed that responsibility for Initiation of Flash Glucose Monitoring no longer needs to be solely with secondary care:

- **For Adults: Flash Glucose Monitoring can be initiated in in both Primary & Secondary care. However, it would be a good opportunity to refer patient back to Specialist Type 1 Diabetes services if not already under their care, however this should not delay the provision of Flash CGM pending Type 1 Specialist review.**
- **For Children and Young People under 16 years old: As all are under secondary care and rtCGM is the recommended first choice then refer to paediatric MDT to support initiation.**
- **For any child/young person with any form of diabetes aged 16-19yrs, if not under secondary care, then as well as supporting initiation in primary care take the opportunity to refer back into the Paediatric / Young Persons service to re-engage and support self-management and transition to adult services (be that secondary or primary care.)**

It was discussed that initiation and review of use in primary care was subject to GPs feeling competent to do so. It was noted a regional approach is being undertaken by the NENC Diabetes Network to train both primary and secondary care clinicians on how to interpret data and assist patients on Flash CGM.

It was agreed that any patients who are not eligible based on NICE/NTAG criteria would require an IFR request.

It was agreed that this updated NTAG recommendation should now be sent to the NENC Value Based Commissioning Group for them to consider updating the regional VBC policy. NTAG agreed to suggest to the VBC group that current separate VBC policies on Flash Glucose Monitoring and CGM need to be considered together as NICE has done rather than in isolation, and consideration should be given to merging into one policy covering isCGM (Flash) and rtCGM. As part of this process the continued need for completion of the VBC checker should be considered. There also needs to some work done at a regional level by the VBC group, involving the Diabetes Network, on which rtCGM devices are commissioned locally from the national procurement framework, taking into account which devices offer the best financial value and accuracy/usability of each device.

ACTION: Secretary to published updated NTAG recommendation and send to VBC group for consideration.

7) Review of Current NTAG Recommendation for i-Port Advance® for Use in Children and Adults with Type 1 Diabetes – to consider including use in Type 2 Diabetes

At its February 2022 NTAG reviewed the current NTAG recommendation from February 2019 for i-Port Advance® for use in children and adults with Type 1 diabetes and considered a request to look at including use in Type 2 diabetes patients. NTAG agreed to add a statement to current recommendation to say reviewed evidence based in February 2022 and found no evidence to support changing the current recommendation at present.

Following the February 2022 NTAG meeting, the NENC Diabetes Network were asked if they wished for the current recommendation to be reviewed and if they had any supporting evidence to consider the inclusion of type 2 diabetes patients within the recommendation. NTAG was also keen to understand what the impact on patients in terms of outcomes and treatment options is because the use of i-PORT is not currently supported in type 2 diabetes patients**.**

The NENC Diabetes Network have requested that NTAG considering adding the following to the current NTAG recommendation to use in patients with Type 2 diabetes:

The Northern (NHS) Treatment Advisory Group recommends the use of i-Port Advance® for use in children and adults with Type 2 diabetes as recommended by specialists for patients that fulfil the following criteria:

• Patients on more than one injection of insulin a day rather than an MDI/basal bolus regimen.

• Patients in whom multiple daily injections are impractical and inappropriate and where use of an injection port may improve glycaemic control.

• Patients with significant anxiety and needle phobia who are avoiding or missing injections.

• Patients with a raised HbA1C > 69mmol /l with poor compliance with treatment or who are injecting into lipohypertrophy despite support and advice to avoid these areas.

• Continued use of i-Port Advance® device to be reviewed every 3-6 months

This because use of i-Port Advance® device in these groups of Type 2 diabetes patients may offer a cost saving in terms of improved glycaemic control and reduction in micro-vascular complications and addition drug therapies e.g. retinopathy and laser, painful neuropathy requiring other oral agents (duloxetine/gabapentin). It was noted that patients with Type 2 diabetes are not eligible for insulin pump therapy.

There is no RCT data to support this request available as the studies have not been done, largely because this a medical device and not a drug. But the Diabetes Network would be willing to audit any use in the region to collect data on outcomes if this request for use in Type 2 diabetes patients is approved.

It is difficult to predict the number of patients with type 2 diabetes who would need this type of device – specialists think a figure of 5 - 10 in the NENC region seems reasonable. There are very few if any patients in paediatrics with Type 2 diabetes on insulin regionally. Importantly patients with type 2 diabetes will not progress to insulin pump therapy as they do not for fill the criteria for pump therapy. The failure to provide the iPORT device for cohort of type 2 diabetes patients could lead to poor control and complications rather than diversion to an alternative insulin delivery modality.

NTAG agreed to recommend the use of i-Port Advance® for use in children and adults with Type 2 diabetes as recommended by specialists for patients that fulfil the following criteria:

- **Patients on more than one injection of insulin a day rather than an MDI/basal bolus regimen.**
- **Patients in whom multiple daily injections are impractical and inappropriate and where use of an injection port may improve glycaemic control.**
- **Patients with significant anxiety and needle phobia who are avoiding or missing injections.**
- **Patients with a raised HbA1C > 69mmol /l with poor compliance with treatment or who are injecting into lipohypertrophy despite support and advice to avoid these areas.**
- **Continued use of i-Port Advance® device to be reviewed every 3-6 months**

This is subject to an audit of use in 12 months to show compliance with these criteria and evidence of positive outcomes.

ACTION: Secretary to update recommendation as above.

8) Regional Adoption/Implementation of Updated NICE Guidelines for Type 2 Diabetes including SGLT 2i Top Tips Document

NTAG discussed the regional adoption/implementation of Updated NICE Guidelines for Type 2 Diabetes regarding the use of SGLT2i published in February 2022.

The February 2022 update of this guideline looked at the clinical and cost-effectiveness evidence for SGLT2 inhibitors in people with cardiovascular disease or at high risk of developing cardiovascular disease. NICE has issued new guidance in February 2022 which recommends their use as early as possible in treatment for type 2 diabetes patient at high risk of cardiovascular disease such as heart attacks and stroke. This is based on studies which now show that these medicines can lower a patient's risk of cardiovascular disease.

NTAG is asked to approve the regional adoption of the updated NICE NG28 guidance particularly around SGLT2i using the NICE NG28 Visual Summary as the regional type 2 diabetes guidance on drug therapy. This would replace existing guidance in the three APC areas in the North East & North Cumbria. This would be supported by the regional Top Tips for Prescribing SGLT2i in Type 2 diabetes.

The focus is on changes to recommendations around use of SGLT2i because these will result in the biggest change in practice and have the biggest cost impact. The recommendations are expected to lead to a change in practice and increase the numbers of people taking SGLT2 inhibitors at the beginning of their treatment or in addition to existing drug treatments.

Based on discussions with diabetes specialists in NENC:

- They agree that approx. 80% of eligible patients are not currently getting an SGLT2i as per updated NICE guidance.
- They expect that if this guidance is implemented this could fall to around 40% of eligible patients not currently getting an SGLT2i as per updated NICE guidance by year 5.
- If implemented, they expect no change in the prescribing rates of canagliflozin and ertugliflozin. Use of dapagliflozin and empagliflozin is expected to increase in a 60:40 split as these two drugs have the better evidence based for CV outcomes, with the evidence slightly favouring dapagliflozin for certain outcomes.
- Currently spend £7.78 million in NENC on SGLT2i which based on assumptions could increase to £25.9 million, a cost impact £18.1 million. This cost impact does not factor in potential savings for decreased prescribing of other antidiabetic drugs in particular sulfonylureas and DDP4i, as these are difficult to predict with any certainty. The NICE recommendations could generate savings if they delay the point at which patients are escalated to more expensive drugs or treatments, and where existing drugs are replaced by SGLT2 inhibitors. Savings may also be made from improved cardiovascular outcomes for these patients in years to come but there is no cost modelling yet available on this.

NTAG felt this updated guidance should be adopted by the ICS as it is NICE guidance and has been the through the NICE process with consideration of the clinical and cost effectiveness of the changes.

NTAG approved the regional adoption/implementation of updated NICE Guidelines for Type 2 Diabetes on drug therapy subject to financial sign off from the ICS.

NTAG also approved dapagliflozin and empagliflozin as the preferred SGLT2i choices in the North East & North Cumbria. This because NICE says to use SGLT2i with proven cardiovascular benefit. Taking the cost effectiveness and clinical results into account, NICE decided against recommending only dapagliflozin and instead made recommendations for the SGLT2 inhibitors as a class. However, they recognised that there was greater uncertainty around the cardiovascular benefits associated with ertugliflozin than there was for empagliflozin, canagliflozin and dapagliflozin.

The latest version of the regional SGLT2 Top Tips in Type 2 Diabetes prescribing guide for GPs was presented to and approved by NTAG. This guidance is currently hosted on APC websites across the NENC (version 7). Previously this guidance was submitted to each individual APC for approval. This can result in regional variation when authors are asked for changes to be made to a document that is already in use elsewhere in the ICS. Following discussion with the author, NTAG asked to approve for use across the region where is it custom and practice for each APC to automatically adopt NTAG ratified guidance. The document is designed to support prescribing of SGLT2i in line with the latest NICE type 2 diabetes guidelines.

ACTION:

Ewan Maule/Jill McGrath to take updated NICE Type 2 diabetes guidance to ICS for financial sign off.

Secretary to published NICE Visual Summary of Type 2 diabetes guidance and send to APCs for local adoption/implementation once received ICS financial sign off.

Secretary to publish SGLT2i top tips document type 2 diabetes and send to APCs for local adoption/implementation.

9) SGLT2i top tips document in Heart failure and Chronic Kidney Disease

These new prescribing guides developed by the regional Heart Failure Network and Renal Network respectively were presented to and approved by the group.

These are new prescribing guides are based on the regional SGLT2i Top Tips in Type 2 diabetes document already approved and in use. Where possible content matches the SGLT2i Top Tips in Type 2 diabetes document.

The SGLT2 Top Tips in Heat Failure is designed to support local implementation of NICE TAs for empagliflozin and dapagliflozin. The SGLT2 Top Tips in Chronic Kidney Disease is designed to support local implementation of NICE TA for dapagliflozin.

It was noted there is not a financial impact in approving these documents as these are both NICE TA approved drugs which have already been approved for addition to local formularies by local Area Prescribing Committees.

ACTION: Secretary to publish SGLT2i top tips document in Heart failure and Chronic Kidney Disease on the NTAG website and send to APCs for local adoption/implementation.

10) Solriamfetol for obstructive sleep apnoea in adults – to archive as NICE TA available

NTAG noted that its Solriamfetol for obstructive sleep apnoea in adults will now be archived as now superseded by NICE TA published in March 2022.

ACTION: Secretary to archive NTAG recommendation on solriamfetol for OSA as superseded by NICE TA.

11) Alfapump recommendation – to archive as device not available in UK

NTAG noted that its recommendation for Alfapump® Device for the Treatment of Ascites Due to Liver Cirrhosis will now be archived as confirmed post February 2022 NTAG meeting that the device is not currently available in the UK.

ACTION: Secretary to archive NTAG recommendation on Alfapump® Device for the Treatment of Ascites Due to Liver Cirrhosis

12) NTAG Decision Summary Liposuction for Lipoedema and Lymphoedema – updated to reference NICE IPGs

NTAG approved an update to the evidence section of the current NTAG recommendation for Liposuction for Lipoedema and Lymphoedema to reference latest the NICE interventional procedures guidance from March and April 2022. No change to the recommendation itself is required.

ACTION: Secretary to update current NTAG recommendation as above.

13) Regional Meds Optimisation Committees Update

No update available. New RMOC North East & Yorkshire Committee is not expected to start meeting until the autumn of 2022.

14) NTAG Annual Report 2021/22

NTAG Annual Report for 2020/21 was presented to and approved by the group.

ACTION: Secretary to send NTAG Annual Report 2020/21 to NENC ICS Board.

15) Review of Current NTAG Remit, Terms of Reference, and Membership

The NTAG Terms of Reference were last updated in November 2018, and although due for review the group had previously decided to wait until the proposed ICS structures were more fully developed.

There is now a need to review the NTAG remit, NTAG Terms of Reference and current NTAG membership as NENC ICS comes into effect from 1st July 2022.

The aim is for NTAG to become the designated North East & North Cumbria ICS Prescribing and Medicines Optimisation sub-Committee with some delegated authority, including financial delegation, from the ICS. In the future the remit of NTAG will include the approval of regional pathways/guidelines for medicines, not just making recommendations on new drugs.

NTAG will in the future be accountable to the NENC Medicines Committee, which in turn is accountable to the NENC Integrated Care Board. Until the NENC Medicines Committee is in place NTAG will be accountable to the NENC Integrated Care Board in the interim.

It is suggested that NTAG work in collaboration with three NENC Area Prescribing Committees to do things once across the ICS.

It proposed that NTAG operates in an interim form with slight expansion/change in current membership until the NENC Medicines Committee and wider ICS Medicines Optimisation Structure is in place. As such representatives from the local authority pharmacist network, AHSN, regional LMC, LPC and NENC Clinical Networks have been invited to join the membership of NTAG.

A briefing paper on the changes to NTAG has been prepared and circulated to the three NENC Area Prescribing Committees.

The updated draft NTAG terms of reference were presented to and discussed by the group. The group supported the updated terms of reference subject to the following changes/clarifications:

- Medical devices – provide some clarity around what would be considered.
- Financial thresholds for delegated authority of NTAG plus deciding what will be considered by NTAG – noted need to wait for ICS structures to be finalised before agreeing these.
- Need to reflect ICS as the commissioner rather than CCGs.
- Need to ensure consideration of sustainability issues as part of decision making.
- Responsibility of NTAG members to seek views from their respective professional groups and organisations prior to meetings.
- Medication Safety Officer representation – may need to consider this in future once ICS structures are finalised.

The importance of having a balanced membership including clinical representation from primary and secondary care was discussed. Also, whilst regional decision making is desirable need to ensure local clinical engagement is not lost.

ACTION: Secretary to make suggested changed and take updated Terms of Reference to July 2022 NTAG for approval.

16) Workplan

The group discussed the work plan.

It agreed to add the following topics:

- Sodium valproate and women/girls of child-bearing potential/pregnancy
- Intranasal adrenaline for anaphylaxis – expected 60-08% switch from pens. No UK launch for licensing date yet

17) AOB

Valproate in Females of Childbearing Potential

It was noted that regional Task and Finish Group was being set up to look at these issues and to try to address some the issues that have been raised around the compliance and completion of the annual ARAF forms that are required as part of the pregnancy prevention programme associated with valproate medicines.

NTAG agreed that as there is no ICS level medicines safety group currently that this Task and Finish Group should report to NTAG, and any regional outputs on this topic should go via the NTAG governance route.

ACTION: Helena Gregory to bring a formal update on the regional work on Valproate in Females of Childbearing Potential to July 2022 NTAG

No other business was raised, and the meeting concluded.

The date of the next meeting was agreed to be 19th July 2022 and will be held virtually via Microsoft Teams.

Minutes produced by G Mankin, Professional Secretary to NTAG, 7th June 2022