Minutes of the **ABUHB Medicines and Therapeutics Committee** meeting held on **17th November** at **13:30** on MS Teams

Present:	Ailsa Walters	AW	-	Pharmacist
	Anne Sprackling	AS	-	Senior Primary Care Pharmacist
	Dr Arif Mahmood	AM	-	Consultant in Public Health
	Christoph Madler	CM	-	Consultant Cardiologist
	David Thomas	DT	-	Pharmacist
	Jonathan Simms	JS		Clinical Director of Pharmacy (Chair)
	Dr Liam Taylor	LT	-	Deputy Medical Director
	Dr Malar Mani	M M	-	Dr, Anaesthetics
	Dr Natasha Collins	NC	-	GP
	Prof. Peter Evans	PE	-	Prof. Physician Medicine
	Phil White	PW	-	Principal Pharmacist Homecare and Prescribing Support
	Richard Wassall	RW	-	Consultant Anaesthetics and Chronic Pain, Pharmacy Lead
	Dr Rob Callaghan	RC	-	Consultant Rheumatologist
	Dr Sameh Bekhit	SB	-	Consultant Psychiatrist
Minutes:	Kelly Eddington	KE	-	Business Support Officer
In Attendance:	James Van Germen	JVG	-	Programme Divisional Pharmacist, Scheduled Care
	Kosta Morley	KM	-	A&E Consultant
	Linda Edmunds	LE	-	Consultant Nurse
	Miss Maike Eylert	ME	-	Consultant Urologist, Special Interest in Female, Neurological and Urodynamic Urology
	Ms Rhiannon Reynolds	RR	-	Consultant Ophthalmologist, Clinical Lead for Regionalisation Cataract Expansion Plans
	Tom Moses	TM	-	Anaesthetic Consultant, Lead for Paediatric Anaesthetics

	Item	***Action***
1	**Introduction, apologies, and declarations of interest** Apologies: - [to be added] No declarations of interest were made at the meeting today. James Van Germen was added to quoracy for Secondary Care at today's meeting.	
2	**Notification of Items of Any Other Business** PE raised the query as to GLP 1(s) becoming Green as opposed to an Amber drug. JS advised that the normal process is to be followed, i.e., in terms of an application. **Action:** To be brought the next meeting, January 2023. No other business was discussed at the meeting today.	PE

3	**Draft minutes from 22nd September 2022 and matters arising**
	• The minutes were accepted as an accurate representation of the previous meeting.
	• The action log was reviewed: -
	  • iAluril TLS change request – Open; maintain status quo as to prescribing at present.
	  • Restless legs guideline – Open; Dr Thomas has attended LMC, awaiting sight of complete pathway.
	  • Visu-Evo – Open, approved Amber, pathway outstanding.
	  • PCSK9i Traffic Light Change – Red to Amber – Open; discussion ongoing as to budget transfer.
	  • Denosumab SCP – Open, awaiting further information from Rob Callaghan.
	  • Melatonin for MRI – Open; discussions ongoing.
	  • Testosterone for menopause SCP – Open; LT to link with Rachel Prangley and noted that the Enhanced Service Group has not yet met.
	  • Heart Failure Clinic Prescribing Issues – Open; Linda Edmunds to join the meeting today.	

	Items for Information / Decision	***Action***
4	***Methenamine for recurrent UTIs*** ***Miss Maike Eylert, Consultant Urologist*** ME attended to present the application in relation to Methenamine for recurrent UTIs. • By way of overview, Methenamine Hippurate is a prophylaxis of recurrent UTI's used when lifestyle changes and over the counter medication such as cranberry products and probiotics have not helped. • The licensed indication is as a prophylaxis for long-term treatment of chronic or recurrent uncomplicated lower urinary tract infection and as a prophylaxis and long-term treatment of chronic and recurrent uncomplicated lower urinary-tract infections in patients with catheters. • The alternative treatment to Methenamine is prophylactic antibiotics and iAluril intravesical instillations, the latter of which is more invasive and requires catheterisation to administer the medication. • The main advantage to Methenamine will be the avoidance of antibiotics, reducing antibiotic resistance in the bacteria which cause UTI's and will also avoid the more invasive treatment options. • There are very few drug interactions and those that are listed are theoretical only. There is a reduced risk of bacterial super infection with CDIFF as Methenamine does not affect the bowel flora. It was noted that it is recommended in the All-Wales Medicines Strategy Group Management of Recurrent Symptomatic Urinary Trapped Infections in Adult Women Guideline as an option, however, this has not yet translated into work to get it onto the All-Wales formulary. • The National ALTAR trial published this year shows that Methenamine is not inferior to antibiotic prophylaxis. A local audit, carried out over the first one hundred patients that were treated over approximately 18 months, showed a 74% response rate with 15% side effects; all sides effects were mild.	

	• Contra-indications are limited - gout, metabolic acidosis, and severe dehydration. Cautions are with hepatic impairment and very low eGFR. • Cost effective; maximum £405.02 per year. • Methenamine has been in use since the 1980s and is on formulary, approved for green, in SBUHB and HDUHB including GP prescribing. CTMUHB is specialist recommendation by microbiology. A discussion ensued with contemplation as regards to Methenamine, after which the group considered the evidence presented to them. On the basis of a vote, the group decided to approve the application for Methenamine for recurrent UTIs; add to formulary – green (80% majority). **Action:** Pathway discussion to be followed up in terms of adding Methenamine into the Antimicrobial Guidelines; three-month review.	JS / Ceri Phillips
5	**Mydriasert (Tropicamide/Phenylepherine) Ophthalmic Insert for mydriasis during cataract surgery** **Ms Rhiannon Reynolds, Consultant Ophthalmologist, Clinical Lead for Regionalisation Cataract Expansion Plans** RR attended to present the application in relation to Mydriasert (Tropicamide/Phenylepherine) Ophthalmic Insert for mydriasis during cataract surgery. • By way of overview, in order to perform cataract surgery, a widely dilated pupil is required. The process is labour intensive requiring a member of nursing staff to put six different drops into the eye(s) at five-minute intervals. • Mydriasert is a small tablet which is inserted into the lower fornix where it gradually releases the active ingredients (Tropicamide and Phenylephrine). It provides a stable anterior chamber when operating in a very widely dilated pupil. The contents of the tablet are the same as is in the drops, there is nothing additional in terms of the active ingredients and Mydriasert will pose no difference in terms of risk factors or side effects. Mydriasert is widely used in the vast majority of Units. • It was noted that the tablet needs to be removed after a maximum of two hours and is generally removed when the patients go into the anaesthetic room to have their local anaesthetic. Documentation will be amended to incorporate an insertion and removal time. • The use of Mydriasert would reduce the workload of staff in the Day Case Unit. Mydriasert is a one-off versus six drops for each patient before surgery commences and this, will in turn, improve Theatre flow. • Mydriasert has been trialled within the Department and patient flow showed improvement and the Nurses are happy to use it. The group considered the evidence presented to them and on the basis of a vote, decided to approve the application for Mydriasert (Tropicamide/Phenylephrine) Ophthalmic Insert for mydriasis during cataract surgery; add to formulary – red (60%).	
6	***Penthrox (Methoxyflurane) Inhalation Vapour for emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain*** ***Pascale Avery/Kosta Morley*** KM attended to present the application in relation to Penthrox (Methoxyflurane) Inhalation Vapour for emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain.	

	• By way of overview, Penthrox is a well-studied drug to include its safety and efficacy, which is being used throughout the UK - Bristol, Southmead, CVUHB, SBUHB and CTMUHB. Penthrox began as a pre-hospital drug and is considered useful for shoulder reductions and other painful procedures within the emergency environment. It is hoped that by using Penthrox it will reduce the use of other drugs which might otherwise be used for such painful procedures. Evidence suggests that Penthrox would be an excellent drug to reduce the use of e.g., Ketamine and Propofol. • PW commented as to the implication of anaesthetic gases, particularly Entonox, on global warming and queried whether an assessment had been carried out in this respect, making mention of Welsh Government, Future Generations Act. KM advised that Penthrox is much safer in terms of other anaesthetic gases and if Penthrox could be used as hoped, it could reduce the use of Entonox. • JS commented as to training and occupational risk exposure noting the need for appropriate ventilation, particularly risk as to the patient expelling back through the device. KM advised that Penthrox is considered a safe to drug to use, even within the confined space of an ambulance. It was noted as to some implications with aeromedical use and reluctance e.g., to use in a helicopter cabin. There will need to be a schedule of training; keeping with doctors at present who will be trained in its use, then moving to other members of staff. • JVG commented as to e.g., renal failure and those under the age of 18 and whether this has been considered/built into the plan in terms of during an emergency. KM advised that this has been considered/built into the plan; paediatric is being looked and there is no intention for use within that group until more information is available. As to renal considerations, it would be used on patients where there is good evidence of their renal function. The group considered the evidence presented to them and on the basis of a vote, decided to approve the application for Penthrox (Methoxyflurane) Inhalation Vapour for emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain; add to formulary – red (88%).	
7	**Oral Midazolam 5mg/ml oral solution (Miprosed) Line Extension** **Tom Moses, Anaesthetic Consultant, Lead for Paediatric Anaesthetics** TM attended to present the application in relation to Oral Midazolam 5mg/ml oral solution (Miprosed) Line Extension. • By way of overview, there are a number of children on the GA MRI list with complex needs (autism, sensory issues etc) who require general anaesthetics for their MRI scans. A lot of the children require Midazolam pre-medication in order to facilitate the induction of their anaesthesia. Currently, intravenous Midazolam is used which is put into blackcurrant/orange squash due to its unpleasant taste. • There has previously been a nicer tasting, specially made, oral preparation of Midazolam but this was withdrawn due to safety concerns (amps). A new company has produced Miprosed which is a nicer tasting oral preparation of Midazolam, and which has addressed previous safety concerns. • TM advised that most of the cases for which the drug would be used would be for the MRI children, elective surgery cases and only with anaesthetic involvement. • It was noted that within the application, mention was made as to the initial supply being free of charge from the company for anaesthesia to trial the new	

	formulation. In line with Policy as regards to samples and free supply, this has been blocked/rejected. The group considered the evidence presented to them and on the basis of a vote, decided to approve the application for Oral Midazolam 5mg/ml oral solution (Miprosed) Line Extension; add to formulary – red (90%), anaesthetics use only.	
8	***Oxycodone use expansion for surgery SBAR*** ***Richard Wassall, Consultant Anaesthetics and Chronic Pain, Pharmacy Lead*** RW attended to present the application in relation to Oxycodone use expansion for surgery. • By way of overview, Oxycodone has been used on formulary for a long time but has been restricted to Palliative Care, Haematology and Oncology. It is noted that ABUHB would like approximately 70% of all surgeries to be carried out under Daycase Surgery in the future which would include knee replacements, hip replacements, hysterectomies etc. Without Oxycodone being open for use on formulary, restricted as at present, it is considered to be a barrier to the development of this future service. • There are a lot of new indications in relation to Oxycodone specifically for Daycase Surgery. Almost all of the protocols involve intravenous Oxycodone to be given intraoperatively along with oral Oxycodone to be given post-operatively with the patient returning home on a tapering downward dose to prevent long term opioid addiction. • Oxycodone has a good renal profile and has lowered nausea and vomiting profiles, although it is suggested that this be kept under review and to see whether more traditional drugs such as MST and Zomorph could also be used. • Cost implication was noted, approximately 1pence extra per tablet but noting and mitigation of the cost by way of comparison of per night for a bed. • JVG observed there may be a slight delay to discharge speed due to having to process the Schedule 2 controlled drug from Pharmacy as these would not be able to be processed at Ward level. • AS raised the question as to how long the patient, upon their return home, would be given Oxycodone? RW advised that for e.g., a knee replacement, this would likely be 5-10 days. • AS raised the question, that, in order to stop repeat requests going to Primary Care, would the totality of the TTO be given from Secondary Care at the point of discharge? RW advised that this is how the model works. • AW raised the possible scenario of a patient presenting at Practice, still in intense pain at the end of the course of their medication, i.e., five to six days post-operation; does the GP carry on the prescription for slightly longer or does the patient go back to the Hospital? RW referred and advised as to the discharge pack and post-operative follow-up - day one and then at seven days. o JVG made mention of building in dropdown menus into CWS; a discharge system to make sure there is a robust contract i.e., this [drug] is for [this] period which will then stop unless the following criteria is met. • Concern was raised as to a potential increase in prescribing of Oxycodone, and it was noted as to managing and controlling of the same. o JS commented that for the planned day case model in the future, it seems likely there will be a number of specific protocols developed which will need to focus on the discharge aspect; both in terms of	

	quantities prescribed and clear durations, advice for GPs, etc. It was noted that, by way of reference point, Surgery and Opioids: Best Practice Guideline 2021 by Faculty of Pain Medicine has some good standards in relation to local protocols for discharge explicitly stating the duration of prescribing to prevent some of the challenges encountered in terms of escalation; Opioid prescribing in Primary Care. As per the SBAR, Oxycodone is amber with initiation by Palliative Care, Haematology and Oncology only. JS suggested, for voting purposes, to remove specialty nature so as to include Daycase Surgery so that it is "…amber with initiation from Specialist Care…". It was noted as second line to Morphine. The group considered the evidence presented to them and on the basis of a vote, decided to approve the application for Oxycodone use expansion for surgery; add to formulary – amber (54%) oxycodone surgical use.	
9	**Cenobamate TLS change form** **Chair** JS provided an overview of the TLS status change form in relation to Cenobamate. • By way of background, this was presented in December 2021 to the High-Cost Drugs Group, but Neurology did not specify where they wanted it prescribed in terms of the Traffic Light Status and therefore the drug was allocated as red by default. As all other oral antiseizure medications are amber and this was an oversight/omission it is requested that Cenobamate be amended/changed to amber. The group considered the request, and it was agreed for Cenobamate to be amended and approved for amber use.	
	Guidelines/Other	
10	**POCU Chart** JVG provided an overview of *the Proposed POCU (Post Operative Care Unit) RGH Fluid Prescription Chart, Assessment and Management of Risks, July 2022.* • The overall purpose of the POCU chart is aimed at standardising and reducing variation on the care provided to ensure that the drug rates on administrations are safe. The POCU chart is proposed to be used on the Post-operative Care Unit - 9 bedded unit in Royal Gwent, which offers Level 2 care to patients. Primarily, the care provided in excess of ward based is the use if vasopressors in the form of Metaraminol. • The chart has been developed from charts within CCU to standardise the Metaraminol and U&E replacements to address inconsistencies with prescribing. The dose stated in the chart reflects the agreed ceiling of care for Royal Gwent. A requirement for a higher rate of Metaraminol would be seen as criteria for stepping up to GUH Level 3 bed. • Arterial flushes have been included due to difficulties in having these prescribed. LT commented as to governance and it was noted that the chart has had Pharmacy, Anaesthetics sign-off and has also been sighted with this group. On the basis that this was deemed as sufficient in terms of sign-off, the POCU chart was accepted.	
11	**Issues around Heart Failure Team Prescribing** LE attended to provide an overview and opportunity to open up for discussion in relation to the challenges and issues with Heart Failure prescribing. <u>SGLT2i</u>	

	• By way of overview, historically, there has been a very good working relationship between a Nurse and the General Practices (e.g., within the Blaenau Gwent area). In this longstanding relationship it was agreeable to confirm the recommendation that was being made, following a heart failure review, via e-mail to those Practices. • There have been a number of staffing changes over recent months and the guidance that was circulated to the new, junior team members was based on the previous model/experience. As such, new staff have begun to email the Practices confirming and asking for some of the drug changes. For the time being, these emails to Practices have been halted and feedback has been requested as to moving forward due to variation and discrepancy between Practices. In feedback already received, some of the Practices have requested communication via e-mail for that 'particular' group of nurses. • It was commented as to potential grey areas in relation to the way in which NICE guidance has been interpreted via the advice and recommendations. Suggestion was made as to the formulary being reviewed, updating some of the language used and interpretation of the same worked through clearly between Primary and Secondary care. • It was commented that clarity is required as to who is giving the advice to start the drug. It was advised that as this is an amber drug, a non-medical Prescriber or the Consultant who is the Clinical Supervisor needs to give the decision to start the drug. o CM commented, for clarification, that patients who are fed into the Heart Failure Service come from the Consultant, with the Consultant having overall responsibility. • It was commented as to the misconception of frequent monitoring being required, particularly for SGLT2i. There is new guidance for cardiorenal protection and CKD (*Prescribing SGLT2i for Cardiorenal Protection in CKD, Aneurin Bevan University Health Board*.). The previous version recommended U&E monitoring post initiation, but post initiation was not mandated and therefore the updated guidance recognizes that this is not required. (Please refer to item 12, SGLT2i guideline update, as below). It was agreed by the group to leave as amber, on the recommendation of a Specialist Service which includes a Prescriber, removing the monitoring requirement and updating the guidance. Education to GPs as to prescribing to be revisited, also noting Patient education (heart failure with diabetes). <u>Entresto</u> • A discussion ensued within the group as to ongoing monitoring within Primary Care / Secondary Care. o It was noted as to Primary care as regards to initiation of the drugs and separately titration, if urgent, request to go to Secondary Care. It was proposed that an outline of how the process should work with the expectation of everyone clearly defined in terms of follow up and titration of dose as regards timing be drafted, which can be communicated more widely. Suggestion was made as to a simplified standard letter which could indicate that the patient has been seen and is clinically stable, with a full clinic letter to follow, a drug change has been made or the repeat prescription amended, adding one line about the patient's medication onto that letter. **Action:** LE to provide guidance.	LE

12	**SGLT2i guideline update** JS provided an overview of *Prescribing SGLT2i for Cardiorenal Protection in CKD, Aneurin Bevan University Health Board*. • The previous version noted that NICE recommended using U&E post initiation. The updated guidance recognises that this is not required and there is now a misalignment between the CKD guidance and the current SGLT2i Heart Failure Pathway, which is on the website, therefore, this guidance needs to be changed accordingly.	
13	**Low Value Medicines update** The `NHS Welsh Utilisation Resource Group is focusing on low value medicines as being a key area that the Health Board should be reviewing. The importance of communication; a reminder of the message about low value prescribing, was noted. AS provided an overview on *Update on Low Value Prescribing September 2022*. • The paper has been brought in order to re-engage MTC to give some steer to the Health Board, Clinicians and Prescribers around prescribing of Low Value Medicines. • Approximately £700,000 has been spent over the last six months in Primary Care in respect of Low Value Medicines with a small contribution on top from Secondary Care. • The main focus is on Lidocaine patches, Liothyronine tablets, Rubefacients, Omega-3, and from a safety perspective, Chloral Hydrate. o In relation to Chloral Hydrate, the value of prescribing is not high as patient numbers are small. From a safety perspective, following MHRA advice last year, it was suggested to identify all patients and review as to the appropriateness of ongoing prescriptions. o In relation to Lidocaine patches, in 2018 the prescribing position was reiterated, and GPs were asked to review patients, implementing a trial without the patches with a follow up review to see how those patients got on and to continue prescribing appropriately, taking into consideration the outcome of that review. It was noted that very little has changed in terms of the overall prescribing position. ▪ AW commented that a review was carried out at the Surgery 2-3 years ago. Approximately 50% of patients were resistant to trialling without the patches and some refused to participate at all. Reduction was around 25% but noting that this was transitory; the biggest issue is the private pain clinic in St Joseph's hospital. It was noted that requests for prescribing of Lidocaine patches is frequent. **Action:** AS to link with RW as to a discussion regarding Lidocaine patches. o In relation to Blood Glucose Strips and Rubefacients, these can be reviewed in Primary Care; Practices can be spoken to individually and appropriate use of ScriptSwitch promoted. o In relation to Liothyronine tablets, there is quite a lot of prescribing in Secondary Care as well as in Primary Care. In 2018 there was a review of all patients, and the subsequent recommendation was that the patients should be referred to the initiating Specialist in order to have a review of the continuation of treatment. Further awareness of and reiteration as to the status of Liothyronine tablets to be raised.	AS/RW

	○ In relation to Omega 3, message for Prescribers to be reiterated.	
14	**Non-formulary requests** JS provided a brief overview of the spreadsheet making particular reference to: - • Methenamine Hippurate • x2 Rituximab • Testosterone	
15	**Formulary requests for next meeting** There are no formulary requests at present for the next meeting.	
16	**Cost-releasing initiatives** There were no cost releasing initiatives on which to focus on the meeting today.	
	National STATUTORY & NON-STATUTORY guidance	
17	***Summary of NICE and AWMSG Clinical Guidance*** The Table of guidance was referred to. No specific actions for the guidance were noted.	
18	***Summary of AWMSG Appraisals***	

Date	Guidance	Drug	Recommended for:	Proposed TLS Status
3/10/22	3017	**Hydrocortisone (Efmody®)**	**is recommended** as an option for restricted use within NHS Wales. It is licensed for the treatment of congenital adrenal hyperplasia in adolescents aged 12 years and older. It is restricted for use as a second-line treatment option in adolescents not adequately controlled on maximum guidelines doses of immediate release hydrocortisone; and as a third-line treatment in adults not adequately controlled on maximum guideline doses of immediate-release hydrocortisone and/or prednisolone	Amber
3/10/22	5196	**Insulin degludec (Tresiba®)**	**is recommended** as an option for use within NHS Wales for the treatment of diabetes mellitus in adults, adolescents, and children from the age of 1 year.	Amber

	3/10/22	3192	**Rituximab (MabThera®)**	**is recommended** as an option for use within NHS Wales for the treatment of patients with moderate to severe pemphigus vulgaris.	**Red**	
	3/10/22	4698	**Lacosamide (Vimpat®)**	**is recommended** as an option for use within NHS Wales as adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalisation in children from 2 years of age to ≤ 15 years of age with epilepsy.	**Amber**	
	3/10/22	4017	**dupilumab (Dupixent®)**	**Dupilumab (Dupixent®)** is recommended as an option for restricted use within NHS Wales. Dupilumab (Dupixent®) is licensed in children 6 to 11 years old as add-on maintenance treatment for severe asthma with type 2 inflammation characterised by raised blood eosinophils and/or raised fraction of exhaled nitric oxide (FeNO), who are inadequately controlled with medium to high dose inhaled corticosteroids (ICS) plus another medicinal product for maintenance treatment. Dupilumab (Dupixent®) is restricted for use in a subpopulation of the licensed indication in line with the National Institute of Health and Care Excellence recommendation for the restricted use of dupilumab for treating severe asthma with type 2 inflammation that is inadequately controlled in people 12 years and over (TA751). Dupilumab (Dupixent®) is not recommended for use	**Red**	

				within NHS Wales outside of this subpopulation.	

JS provided a brief overview of each and the x3 drugs as listed below were agreed and accepted for inclusion as Amber: -

- 3017 Hydrocortisone (Efmody®)
- 5196 Insulin degludec (Tresiba®)
- 4698 Lacosamide (Vimpat®)

19 ***Summary of NICE positive FADs, FEDs, and TAs***

Date of FAD/TA	Guidance	Drug	Recommended for:	Proposed TLS Status
23/08/22	ID3852	**Atezolizumab**	for adjuvant treatment of resected non-small-cell lung cancer	**Red**
2/9/22	ID3892	**Azacitidine**	for maintenance treatment of acute myeloid leukaemia after induction therapy	**Red**
16/9/22	ID3810	**Pembrolizumab**	for adjuvant treatment of renal cell carcinoma	**Red**
6/9/22	ID3841	**Ozanimod**	for treating moderately to severely active ulcerative colitis	**Red**
15/9/22	ID1427	**Zanubrutinib**	for treating Waldenström's macroglobulinaemia	**Red**
23/9/22	ID3908	**Pembrolizumab**	for adjuvant treatment of resected stage 2 melanoma with high risk of recurrence	**Red**
23/9/22	ID3779	**Palbociclib with fulvestrant**	for treating hormone receptor-positive, HER2-negative, advanced breast cancer (Review of TA619) (AWTTC #3626)	**Red**
19/10/22	TA835	**Fostamatinib**	Fostamatinib for treating refractory chronic immune thrombocytopenia	**Red**

JVG made mention as to ID3892 (Azacitidine) and provided an update: -

	• Haematology has no plan to use Azacitidine for the foreseeable future but there is movement to repatriate the AML patients, for which it will be used, into the Health Board. All of the implementation paperwork has been completed.	
	Drug Safety	***Action***
20	**MHRA Drug Safety updates – September and October 2022** For information: - • Volume 16 Issue 2 September 2022 • Volume 16 Issue 3 October 2022	
	Feedback from Subgroups	***Action***
21	**Medicines Safety Group** – No update. There is a meeting next Monday. **NMP Meeting** – Lyn Middleton is seconding to WG and there will be an additional member from Nursing once her replacement joins. **MH&LD D&T Group** – No update. SB raised the query in terms of Primary Care initiating prescribing cognitive enhancers, anti-dementia medications (Memantine, Donepezil etc). A discussion ensued. As per a previous conversation with Psychiatric teams and following NICE guidance that a diagnosis of dementia requires a Specialist Assessment, it was clarified within the group that no medication would be prescribed without a clear diagnosis. It was noted that the biggest issue in prescribing is the delay in receiving the letter requesting initiation of the drug without a diagnosis; a detailed diagnosis often taking some weeks or months to follow/arrive. It was agreed that the current prescribing model works. SB will reiterate the message to the Old Age Consultant Psychiatrists Forum that medication is not to be requested without submitting a clear diagnosis. **PGD Approval Group** – No update. **Wound Management Group** – No update.	SB
22	**Any other business** It was noted that Emily Knight has now left post. Will Batten will be joining on 3rd January 2023.	
23	***Date of Next Meeting:*** Thursday 19th January 2023 ***Venue*****:** via Microsoft TEAMS	