

MINUTES OF THE WWL MEDICINES MANAGEMENT STRATEGY GROUP (MMSG)

Friday 16th September via Microsoft Teams

PRESENT	Aug 2021	Oct 2021	Mar 2022	July 2022	Sep 2022	%
Medical Director (Chair) S Arya (SA)	✓	A	✓	✓	A	60
Director of Pharmacy (Vice Chair) M Parks (MP)	✓	✓ (Chair)	✓	✓	✓ (Chair)	100
Divisional Medical Director (at least one to attend) A Ashish (Ash) (Medicine) C Zipitis (CZ) (Surgery) S Talwalkar (ST) (Specialist Services) P Bliss (PB) (Community)	A	A	ST	A	A	20
Clinical Directors (at least one to attend) Harish Sreenivasa (Child Health)	MM	RN	A	HS	HS	80
Consultant Microbiologist/Antimicrobial Pharmacist R Nelson/Dr C Faris/Dr Z Fang/ Mr M Davies	MD	RN	MD	MD ZF	MD ZF	100
Wigan CCG Representation [REDACTED] [REDACTED] [REDACTED]	[REDACTED]	[REDACTED]	LS	LS	[REDACTED]	100
Nursing/Governance Representation (Medicine) K Fisher (KFi) Divisional Head of Governance R McCarren (RM) Divisional Director of Nursing K Whiteside (KWh) Deputy DDON A Murphy (AM) Matron, Emergency Medicine	A	JL	KFi RM	KFi	RM KWh AM	80
Nursing/Governance Representation (Surgery) S Howard (SH) Quality & Safety Midwife E Doyle (ED) Divisional Head of Governance N Heath (NH) Deputy DDON A Cropper (ACr) Matron, Maternity J Barrett (JB) Divisional Director of Nursing/AHP	JB	JB	SH	ED	ED ACr NH	100
Nursing/Governance Representation (Sp Services) S Russell (SR) Physiotherapist Lead F Hindley (FH) Deputy DDON [REDACTED] [REDACTED]	FH	FH	SR	FH	[REDACTED]	100
Nursing/Governance Representation (Community) A Barlow (AB) Divisional Head of Governance A Cooper (ACo) Specialist Safeguarding Nurse	SBF KD	A	AB	AB	AB AC	80
Ass. Director of Pharmacy (Governance & Risk) G Masterman (GM)	✓	✓	✓	✓	✓	100
Ass. Director of Pharmacy (Clinical Services) R Ball (RB)	A	✓	✓	A	✓	60
Pharmacy Secretary [REDACTED]				✓	A	50

In Attendance:

C Goodman (CG) – Consultant Anaesthetist
 D Buck (DB) – E-Prescribing Specialist Pharmacist
 J Smith (JS) – Practice Education Facilitator
 K Ferguson (KFe) – Medicines Safety Pharmacist
 M Farrier (MF) – Associate Medical Director
 N Patel (NP) – Consultant Anaesthetist
 V Loftus (VL) – Medicines Safety Nurse

Item No		Action
1	Apologies for Absence & Committee Chairs Opening Remarks Attendance and apologies were as recorded on the previous page.	
2	Previous Minutes The minutes were accepted as a true record	
3	Action Log	
3.1	Mar-22: 11/22 - Controlled Drugs Audits – Red areas <i>Each of the Divisional Head of Governance to review their CD assurance report, identify the top 3 areas of concern and report back the actions to improve at next MMSG</i> - GM advised that unfortunately KPr couldn't attend, a lot of Medicine division work was around A&E - has shared the Emergency Village improvement plan with the group which was comprehensive. - Surgery don't currently have a Principal Pharmacist (in recruitment), GM attended surgical DQEG in the interim - the results of the CD and Safe and Secure audits have been discussed there and Division advised will be tackling the red areas and ongoing concerns. - [REDACTED] advised that Specialist Services advised they have had quite a few changes to their team, advised they will be looking at the most recent audits and work on the areas of concern from there, take those to the MSK governance meetings and monitor improvement through the current meeting structure. - ED added that in Surgery division they have regular walk-rounds which will be looking at certain CQC/KLOE issues and CD audits will be one of them. MP advised that this needs to be a continued focus, so will look at this at the next MMSG meeting with the updated data and continue to share data via Divisional Governance structures in the meantime so that ward managers can be sighted on and lead improvements in their areas. Action Complete	
3.2	Mar-22: 20/22 - Discussion of opportunities for reducing carbon footprint of medication at WWL <i>Present at next MMSG identified themes for work up around reducing carbon footprint w.r.t. medication at WWL</i> - CG shared his presentation; "Going Green! Reducing the NHS carbon Footprint" which was well received by the group and generated significant discussion around the potential opportunities for this at WWL. - NHS pledge to be net zero by 2040 will take real work but as NHSE is biggest employer in Europe can use that size and influence to drive down emissions. - Schemes discussed were ; ditching desflurane, TIVA support, reducing NO ₂ , reducing IV paracetamol, waste reduction and increased recycling (prefilled syringes were mentioned as a specific safety issue that was contributing due to overstocking and wastage).	

	<ul style="list-style-type: none"> - Issues with nitrous oxide leakage from piped systems and 98% wastage was discussed as a priority for the trust with support from MMSG. - ACo raised a question regarding how proposed reduction in use of nitrous oxide would affect home birth settings, CG advised this would be an in-hospital initiative as the equipment would be too large to transport in cars. - MF advised there is a greener WWL overview group set up called 'Net Zero' and developing green medicines and medical pathways which are in the early stages, significant improvements have come from anaesthetics and CG and GP are great exponents of this. He explained the need for change especially in some of the mindsets and getting all staff used to a new way of working which would be environmentally friendly. In the face of such wastage and environmental damage he urged us to take the necessary risks to make these changes. - NP advised the Medclaire device referred to in the presentation is a large piece of equipment and costs about £30,000 per unit. Hopefully if more people using this the cost will effectively go down. It does take a bit of training for the patient to use it because rather than breathing through a mouthpiece, they must breathe into a mask itself. Looking at the evidence we are wasting 98% of our nitrous oxide. - ACo advised that we need to make sure we have safe processes in place from a risk assessment for fire and other risks, we would need somewhere suitable within each delivery room to be able to store the Entonox cylinders for patient use. Maternity expressed their concern for changing the Entonox to cylinders as it is used a great deal. NP advised that the first phase is piped nitrous oxide rather than the Entonox – this will be discussed further as plans for review of piped nitrous oxide continue to be developed and assessed. - MP thanked CG for the presentation and the group for the engagement and discussion and summarised that it was clear that there was support for this so needs to go to CAB/Exec approval and to continue to report back progress with these schemes mentioned and green inhaler work to this group. Maternity Entonox was acknowledged as an area that would need further specific discussion to ensure that any risks from the proposed changes were appropriately mitigated. 	
3.3	<p>Jul-22: 23/22 – Cover for Trust Compliance Lead role in attendance <i>Discuss with Ehsan Haqqani, Associate Director of Governance and Patient Safety for an appropriate colleague to cover for Trust Compliance Lead and invite to next meeting.</i></p> <p>GM advised the appropriate colleague would be the interim trust compliance lead and she will be added to the invites for the next meeting. Action Closed.</p>	
3.4	<p>Jul-22: 25/22 – Reducing Carbon Footprint of Medication <i>Agenda to be updated to add this as a standing item section on future meetings of MMSG</i></p> <p>This was covered within presentation and discussion at this meeting and GM will add to future meetings as an agenda item as agreed under 'Caring'. Action Closed.</p>	
3.5	<p>Diabetes Management Action Group Report <i>Report to be presented at the next meeting detailing the progress of the diabetes working group</i></p> <p>This requires divisional sign off before it can be signed off and will go to the Patient Safety Group next week and then for approval at ESG. Once this has been done it will come back to this group for the next meeting in November. Bring back next time.</p>	

3.6	<p>Review of the GP queries to Trust Antimicrobial Service <i>ZF/MD to check the 20-25 GP queries to determine any themes/trends and to see if they could be answered from available resources (guidelines/formulary) instead. Will report back at the next meeting in September</i> Discussion around this topic was covered under antimicrobial section. Required work on this topic has been completed but the report needs putting together Bring back next time.</p>	
4.	<p>Greater Manchester Integrated Care Update AS presented an update from GMICS (Wigan Locality).</p> <ul style="list-style-type: none"> - Primary care are doing work on inhaler switching where they can to dry powder inhalers, looking at inhaler technique and starting a project on wasted medications including transport and incineration considerations. - Medicines optimisation peer reviews have started on drugs of dependence from a patient safety perspective - Discussions on diabetes as this is one of the locality priorities and they are doing a lot of work with primary care colleagues on the RightCare process to make sure people are being monitored as they should, so they see complications earlier but also on the management of HbA1c and blood pressure to get optimal patient outcomes. - Phase 5 of the covid vaccination programme has started and they are prioritising the care home residents and clinics. AS thanked WWL for facilitating the use of the Sephton Unit at Leigh infirmary for the Leigh PCN - Flu vaccination programme has also started, they have restarted the flu group and changed the format of that group, hopefully going forward so that they can focus on inequalities and how they might take action in different areas. The first one will be for pregnant ladies because the data shows they have a low uptake in this area. Looking forward to working with WWL maternity services to make improvements there. - The GM Chief Pharmacist job is being advertised so hope to have someone in that important role in the coming months. 	
5	SAFE	
5.1	<p>Medicines Incidents Report GM spoke to the report that had been attached to the agenda.</p> <p>GM advised that the report was here for discussion, approval and any amendments before it gets shared externally as is for Trust Q&S and Wigan IQSG next month. The report was on the agenda for information but specific points that GM pulled out were;</p> <ul style="list-style-type: none"> - We are reporting appropriate numbers of medication incidents (mostly no harm which is good) across all locations including community. - Did notice it dropped off a little bit over the last couple of months so have asked for a push from meds safety team who will go out and encourage people to report and try and get those figures back to where we would expect from an organisation this size. - The NLRS is moving over to a different organization but there isn't any more up to date benchmarking information than what was available in 20. Based on that our reporting is as it should be, but it would be good to have updated data to be sure this is still the case. - We have information around the improvements that the med safety group have been doing around controlled drugs, we had a lot of controlled drugs volume wastage so have implemented CD rulers which are bespoke per brand rulers that you put against the outside of the package which means that we no longer need to use measures which lose liquid and doesn't please our infection control colleagues. 	

	<ul style="list-style-type: none"> - Antimicrobial order sets on HIS which means now if a prescriber selects 'chest' or 'urinary tract' etc it will bring up the right antibiotics for them which results in GIRFT, every time. - We have really good yellow card reporting which continues to be top 3 in the region. - The regional medicine safety officers are doing work around clozapine with our partners in GMMH, there were a few clozapine incidents noted. It's a drug that is subject to strict monitoring as incorrect use can be fatal – this combined with low frequency of use and awareness of the drug make it a specific drug of concern for us. - Issue with bowel prep but managed to work together with the divisions and prescribers and change over to a completely different product in an amazingly short timescale, which given the ERF numbers going through the system was excellent team working. - Medicines safety team have managed to deal with the initial influx of extra nursing staff drafted in to help the situation and is in conversation with the senior nursing colleagues to try and secure more resource for medicines safety nursing so that this support may be maintained. 	
5.2	<p>Review of SUI related to medicines (GM) GM spoke to the report that had been attached to the agenda and discussed those StEIS incidents that involved medication.</p> <ul style="list-style-type: none"> - GM assured the group that we don't do any of the approval or processing of the serious incidents through this body, they all go through executive scrutiny group and then onto the CCG SINE panel. There is a full internal process that gets followed. The incidents were discussed for information - Theme around diabetic management was identified and a working party formed. As per the action log the updated will be coming back to the next meeting from KFi. - Had an extravasation following phenytoin where because of lack of access, phenytoin was administered into a vein in the hand. Audit of nursing awareness of sources of help and information as well as knowledge on this area has been commissioned by ESG. - Patient who had cardiac arrest following adenosine infusion. Past history of COPD meant that it was contradicted. As the patient went on to pass away sometime afterwards, felt adenosine wasn't contributory but there were questions raised over the appropriateness of the opiates used so that has gone for external review. - Patient with AKI and dehydration – went NBM, had PD medication but didn't have Parkinson's disease that was omitted. Had a neurology condition that required liaison externally with Salford Neurology team and how the medicines management was supported in that situation will be looked at as part of the investigation. 	
5.3	<p>Risk Register GM spoke to the report that had been attached to the agenda.</p> <ul style="list-style-type: none"> - At the last meeting the main risk was around vulnerabilities in IT and if the computer systems could be accessed externally was a risk. The risk has progressed and now the only remaining action is to replace the robot PC – hoping this will be done by the next MMSG so we can remove this risk. - Failure of pharmacy robot will continue until it is replaced – company won't give a date for this so continue to repair it as we go (frequently). - Risk of diversion of schedule four and 5 controlled drugs is in discussion with DDONs - GM thinks it can be reduced because we have implemented all the mitigations we can. Remaining action is the review of supply vs consumption data to be concluded by end 2022 (as discussed at last meeting) - Clinical room temperatures and fridge temperatures – business case is written, waiting for one supplier to come back because of the value GM needs to get 3 	

	<p>quotes. This feeds nicely into the theme of the meeting of avoidable wastage as although it will cost around £50k - £60k to implement (then £10k recurrent), in the last 12 months there has been a waste of nearly £70k worth of medication because fridges are not being checked and not being escalated when they are out of range. If this annual wastage is removed, it will have a massive impact on our overall environmental impact</p> <p>- Other three top pipeline risks are something that has been being discussed the DDOPs for Medicine and Surgery as well as the Deputy Chief Executive – they all concern staffing resource and ability to safely provide pharmacy services:</p> <ul style="list-style-type: none"> ○ Wrightington staffing to support elective recovery can't cope and ensure all patients reviewed and kept safe ○ Homecare pharmacy service remains unfunded despite a value of over £7m a year. Numbers of patients were rising anyway then a massive spike due to Covid and now no appetite to change that. Over the last 5 years, dermatology has increased by 380%, rheumatology by 157% and gastroenterology by 463%. ○ Sickness/absence, staff leaving and inability to recruit see the pharmacy service down by 18% of establishment meaning that there are severe gaps in ability to provide service. Escalation plan developed and anything that isn't patient safety or direct clinical care is facing delays or cessation in service. <p>- MP added that from a pharmacy perspective they have significant gaps in the service in particularly the principal pharmacist ranks, the ability for them to support divisions have been hampered significantly by some vacancies. Have some immediate actions that they may be able to take to keep the service running, some of the medium-term actions that can be taken and some of the strategic sort of stuff which will be taken away which will need working through both within divisions but also across the trust as well to try and support the teams to be able to support the divisions, medical nursing colleagues and the patients in a safe way.</p> <p>- RB advised once they have fully formulated the escalation plans these will be shared with Division of Medicine</p>	
5.4	<p>Antimicrobials (MD) MD presented update.</p> <p>- Medicine's Divisional Audit was completed in August, and MD is doing the final comments on that from Dr Faris and then will just need a distribution list which will include consultants and ward managers so this can be rolled out.</p> <p>- CQUINs – this is publicly available on Public Health England 'Fingertips' system</p> <ul style="list-style-type: none"> ○ Didn't perform very well in terms of the compliance to national standards for managing UTI in patients who are over 16, it looked at four key areas and the main one is to do with whether documented indication matched any symptoms that were written in clinical notes if a urine dipstick was done in over 65s and if urine cultures was sent. We scored 25% compliance only. ○ One of the main actions from this is the suggestion that they remove the capability of some adult inpatient wards having access to urine dipsticks that have the potential to test for nitrates, MD isn't aware of any other conditions where we use urine dipsticks to test for nitrates other than assessing whether there is presence of bacteria in urine. MD asked whether we can remove these – is this something that MMSG can rule on? <p>- MF advised that from the Deaths Audit he does each week there had been two patients who were said to have a UTI although neither did. Frailty and dementia/confusion but we assumed UTI incorrectly</p> <p>- MP spoke about JHRU experience and that it was fairly routine to see antimicrobials particularly for UTI started at a very low threshold with very little clinical evidence to support that.</p>	

	<ul style="list-style-type: none"> - GM suggested this may need to go to the new 'CAB' to make sure all clinicians are consulted as this will need to be considered by everyone. - ZF felt that dipsticks were good for excluding UTI, however they are not a tool to diagnose UTI and so we need to reduce this. He felt we need to look at this again and review the rules - MD advised of a big PHE update on guidance for diagnosis of UTIs in all ages and once this is rolled out he will look to set up some training for clinicians. When these are launched it will give us a tool to audit and challenge practice against. - MP advised MD to speak to the urologists before going to CAB as he recalled that they had objections with removal of dipsticks last time this was discussed. - [REDACTED] asked that when the report of queries from GPs for advice was collated if she could receive a copy and meet with ZF and MD r.e. how to improve before it was sent for wider discussion. This was agreed as this would likely lead to more appropriate actions that could be implemented in both primary and secondary care. - ZF added that although they had been given funding for extra middle grade support in microbiology the only applicant withdrew. As such will try again. 	
5.5	Patient Safety Alerts, Drug Alerts and Recalls (GM) GM spoke to the document that had been attached to the agenda. GM advised nothing is breached and assured the group that they are responding appropriately to MHRA alerts.	
5.6	Litigation (MP) MP confirmed that there were not any cases of litigation pertaining to medicines management at the time of the meeting.	
6	EFFECTIVE	
6.1	Dashboard: Safe & Secure / CD Audits and Omissions <u>Safe and Secure Audits</u> <ul style="list-style-type: none"> - Did 153 inspections in august which is a huge piece of work, overall found the compliance was around 92% and is stable over a long period of time. - Leigh needs some focus as there is a challenge around some of the clinical areas. - Pharmacy teams continue to challenge where needed and support ward/dept managers to improve their areas where deficiencies are seen. - <u>Controlled Drugs Audits</u> <ul style="list-style-type: none"> - Did 80 inspections in August and this has increased despite the staffing levels being challenging. We had a strong focus on these being completed despite that as deficiencies here can cause harms and indicate other problems at ward/departmental level. - Performance quite static in terms of overall scores - Red areas were discussed – Shevington, Astley, MAU although Emergency Village and Langtree had improved and dropped off the bottom – structured work was done in those areas so encouraging that this could have positive effects <u>Omissions Reports</u> <ul style="list-style-type: none"> - MP advised that we review around 60k lines a month for this report - Code not recorded totals and in particular critical medicines without a code has increased which is a concern for the group and MP asked Divisional teams to work with ward managers to improve this. Work needed with Jean Heyes and Ward A around improvement particularly in this area 	

	<ul style="list-style-type: none"> - MP did advise that we have had issues around data quality in the past (such as patients discharged) and so will speak to DBu regarding work on this outside of the group. Another issue is the '#name' data which refers to assign beds – work is ongoing on these generally within the organisation. NH asked whether ongoing omissions could be due to this and MP and DBu confirmed that this could be. - MP explained that there are issues on wards with 'route not available' Shevington, Langtree and Winstanley need a piece of focus work to support staff to improve the area. - Drug unavailable is more complex than it would appear as often on investigation the drug is on the ward but not located by staff - CAU and discharge lounge need work with this now that they have been provide pharmacy support. They shouldn't be topping this list. - DBu came on to difficulties regarding failure to maintain real time data on wards and gave some of the examples of this such as a patient being sent home on a Monday afternoon but the system stated Wednesday afternoon so there was 3 days of omitted medication. - MP felt that this was another area that a second Medicines Safety Nurse would help to unpick if we could get funding for that. - MD felt that we had seen issues with omissions on DL being linked to them as the final destination rather than the ward they actually occurred on so DBu will look into this further. 	
6.2	<p>NICE Report</p> <p>GM reported that as usual the compliance with NICE guidance was very good although there were some that had breached and had been escalated accordingly:</p> <ul style="list-style-type: none"> - TA741 and TA742 are both drugs for prostate cancer via Christie. The responsible consultant has been contact several times including by the Medical Director but has yet to provide the required information for these – due date was January 2022 - TA773 a drug for heart failure that was sent to the wrong cardiologist. This was sorted but we still haven't had a response and it has been raised at Medicine Division governance groups. That was due back June 2022. - GM reported that the pressure is on him at the moment as without Principal Pharmacists in Surgery and Medicine (as discussed under risks) he is having to sort these. So far managing but is a lot of extra work - TA792 for ulcerative colitis haven't had a response from consultants and will breach next week – GM will take that on and go speak to them to sort this - TA799 and TA800 for ophthalmology will also breach next week - the consultant has been on leave so GM will liaise when they are back to get those signed off as well - Other NICE guidance is due back end of October and later so GM will continue to try and get these through as smoothly as possible 	
6.3	<p>PGD Report</p> <p>GM spoke to the report and raised concerns that some of these were falling short of timely review and re-approval. He restated the fact that the responsibility on ensuring these are reviewed and reapproved are with the author and if they breach they are removed so no services can carry on with them in use.</p> <ul style="list-style-type: none"> - Emergency Village PGDs have gone to the consultant for sign off, GM had advised the team that they can't be used until sorted. DBu had run a report and found that some of them were still being used. Was escalated to the Deputy DDON for Emergency Medicine who has worked with the teams to stop this until approved. - Cancer Care PGDs have expired and are going through the reapproval process - CCOT PGDs have expired but we still aren't completely clear which are needed as many of the CCOT practitioners are NMPs – the service lead is liaising with our Specialist Critical Care Pharmacist to sort this out. 	

	<p>- A set of radiology PGDs have breached and as yet we haven't had a response from the author, so they remain expired and unable to be used. This set in particular is indicative of the pressure on the Wrightington site already discussed. LHF offered to help get these through the governance process within specialist services as soon as possible.</p> <p>In better news GM was able to advise that he had worked with the COPD consultant and specialist nurses to review and update their 21 PGDs that were expiring at the end of the month. They were all added to Medicine Division September meeting so will be approved in time.</p> <p>Horizon scanning was shared with the Divisional teams so they can ensure that the authors & consultants review them in good time and submit for Divisional approval prior to expiry:</p> <ul style="list-style-type: none"> - Emergency Village – 4 more PGDs Oct-22 - Arthroplasty Practitioners – 6 PGDs Oct-22 - Physiotherapists – 6 PGDs Oct-22 - Paediatrics – 9 PGDs Nov-22 - Endoscopy – 9 PGDs Nov-22 - Cardiology – 3 PGDs Dec-22 - Ophthalmology – 15 Written Instructions Dec-22 <p>GM will continue to support this work as best he can under the current pressures. MP added a reminder that teams operating under PGDs need to ensure that all staff doing so have been trained in their use and have signed a local register to affirm that this is the case. He advised area leads to go and check that this was the case.</p>	
7	CARING	
7.1	<p>Complaints</p> <p>The recent medication related complaints were attached to the agenda for information and GM pulled out any key themes as usual:</p> <ul style="list-style-type: none"> - Patient expectation was a theme in that often the complaints were due to us not explaining and involving patients in decisions around medicines. If we had given the patients the facts, then several of the complaints this month could have been avoided. - Stress in the system was apparent in terms of delayed clinic appointments, delayed changes in medication - There weren't any serious harms in the complaints but GM commented that obviously each one involved a patient where they felt that we failed them in some way and so we should read them and learn the valuable lessons they gave us. <p>No further comments were made around the complaints</p>	
7.2	<p>Engagement</p> <p>RB discussed engagement within pharmacy and medicines management:</p> <ul style="list-style-type: none"> - Pharmacy was nominated for a star award and she was glad as she was extremely proud of the team under the pressure that they are facing now. - RB has been running audits on nurse satisfaction, doctor satisfaction and patient satisfaction and has some feedback (nurse survey isn't written up yet): <p>Patient satisfaction comments that we are looking into:</p> <ul style="list-style-type: none"> - In Pharmacy there is only one chair which needs looking at. We had to remove them to create required distancing during Covid but really this can and will be looked at again as isn't appropriate when many of our patients have mobility issues. 	

	<ul style="list-style-type: none"> - Missing remote control for the TVs so unable to work them, some PR work needs to be done to make the area more attractive whilst waiting for your prescription. - Some complaints were raised around lack of privacy so we have made a chaperone poster and will display that so if anybody would like to speak to someone privately, we can facilitate this. - Some complaints received that it can take 20 minutes for a prescription – there is sometimes a lack of awareness of the checks needed for prescriptions. It isn't just putting a label on a bottle from the shelf. We do try and keep patients updated and reduce delays to a minimum <p>Doctor satisfaction –</p> <ul style="list-style-type: none"> - Had lower numbers this time than we have had before, and RB was wondering if this was down to not being invited to do the FY1 induction training last time. RB has a meeting with the education lead to look into this and resume that connection and training. - Everyone seems really happy with the service but would like 24/7 opening but understand isn't possible or financially viable – the On-Call service is there to bridge this gap. - Was mentioned they don't feel they get the full services when a pharmacist is covering two wards. This is understandable – we do ensure that the pharmacy teams are ward based but we don't have enough staff to cover every ward all day. It was good to see that the benefit of the ward teams was appreciated. 	
8	ITEMS FOR APPROVAL	
8.1	<p>Nursing Associates (NAs) and Medicines Administration SOP (v2)</p> <ul style="list-style-type: none"> - JS advised they have taken this to their colleagues and NMAHP body meeting for some feedback around the content and some of the changes. -The SOP has been in place since 2019 and we've just amended some of the content just to reflect changes in practices for this group of nursing associates for this part of our workforce. - Following NMAHP review it was felt to be too lengthy and stripped back (changes documented in red) - The original version came from region as the initial roll out of NAs was done at regional level. It is hoped that this updated version is more logical and easier to read. - Second checking details have been amended including around insulin. - VL added that after the Diabetic Working Group they clarified that a NA can be second checker for insulin only with a senior registrant - Single sign CDs wouldn't be appropriate for NAs to administer either - Training for NAs has been streamlined as described in the updated SOP - No comments were received before or at the meeting. <p>APPROVED AT THE MEETING</p>	
9	ITEMS FOR INFORMATION	
	<p>The minutes of the last two meetings of the Pharmacy Quality & Safety Group (PQSG) and Medicines Safety Group (MSG) were attached to the agenda for information.</p> <p>No comments were raised on any of the items for information.</p>	

10	ANY OTHER BUSINESS	
10.1	<p>JB mentioned she had seen the email regarding feedback from one of the Bed Managers who had spent the day in pharmacy. She felt it was a reflection of the hard work that pharmacy do in ensuring medicines safety and efficient flow and the many problems that they have to overcome to achieve this.</p> <p>She said that all Divisions need to try and improve on the points raised and that it was clearly not something that was due to the drugs being the cause of the delay. She will discuss in her senior nurse meetings as a day in the life of pharmacy is something that they should all experience probably for context and understanding of the issues.</p>	
10.2	<p>MP brought up the Medicines Management Strategy and mentioned he met with Mary Fleming the Deputy Chief Executive and discussed around opportunities to improve pharmacy service, one of them was a refresh of the Strategy.</p> <p>MP wants to have an updated version ready to go out before year end. Will include in discussions for the next meeting. MP asked members to discuss with teams and bring back proposed inclusions for a discussion at the next meeting. The more radical and thoughtful the better as the Medicines Management Strategy is for us all to be involved with. New Action</p>	All
11	TOP RISKS AND SUCCESSES	
11.1	<p>Risks:</p> <ol style="list-style-type: none"> 1. Staffing levels in pharmacy at an unprecedented low level 2. Environmental issues require a lot of further work to get to Net Zero 3. PGD compliance – large number expired and reduced Principal Pharmacist support to help the teams get this back on track 	
11.2	<p>Successes:</p> <ol style="list-style-type: none"> 1. Attendance of group – all Divisions represented 2. Dr Goodman's Go Green presentation and the discussions/further work on the green agenda 3. The number of Safe & Secure and CD audits done for august despite the low pharmacy staffing numbers 	
12	DATE, TIME AND LOCATION OF NEXT MEETING	
	<p>1pm – 3pm Friday 11th November Via Microsoft Teams</p> <p>Then: Friday 13th January 2023, 1pm – 3pm via Microsoft Teams</p>	