EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

NEW DRUG AND INTERFACE GROUP

MINUTES OF THE MEETING HELD ON WEDNESDAY 7th December 2016
IN PINK ROOM, GROUND FLOOR, B BLOCK, ST HELIER HOSPITAL

Present:
Dr V De Silva (Consultant Nephrologist) **VDS (Chair)**
Dr R Shephard (Consultant Neonatologist) **RS**
Anne Davies (Chief Pharmacist) **AD**
Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC**
Anne Lowson (Secretary) **AL**
Sophie Bye (Senior Pharmacist Sutton CCG **SB**
In attendance:
Sumbo Adeyemo (Medicines Management Pharmacist) **SA**
Vanya Slavova Boneva (Medicines Management Pharmacist) **VSB**
Nicholas Luu (Pre-reg Pharmacist) **NL**
Maiko Kokubun (Senior Pharmacist) **MK**
Miss A McElvanney (Consultant Ophthalmologist) **AM**
Dr A Tewari (SpR in dermatology) **AT**

No	Item	Responsible for Action
1.	**Apologies for Absence** Dr P O'Mahony (Consultant Stroke Physician) **PO** Dr M Gardner (Consultant Anaesthetist) **MG** Dr L Mulleaue (Consultant Anaesthetist) **LM** Susie Mallinder (Lead Renal Nurse) **SM** Dr R Scott (Joint Medicines Management Lead – GP Sutton CCG) **RS** Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST** Dr S Moodie (Consultant Gastroenterologist) **SM** Sharon Kitcatt (Consultant Nurse – Acute Pain Service) **SK** Dr A Pitsiaeli (GP – Surrey Downs CCG) **AP** Dr J Bendig (Consultant Microbiologist) **JB** Dr S Patel (Chair) **SP** Dr Mahmood (Consultant Gastroenterologist) **AM**	
2.	**Declarations of Interest** No additional declarations of interest for this meeting from members or from the new drug presenters.	
3.	**Minutes of the Meeting held on the 12th October 2016** Minutes were agreed with one typographical error on page 8 (should read initiation rather than inhalation.)	
4.	**Matters Arising**	
a)	**Ranibizumab Switching Policy** Mr Saeed is will be contacted now he is back from extended leave.	**AD**
b)	**SWL - Pathway for Melatonin** Meeting has taken place with Dr Veermak (consultant paediatrician, Niel Kenny and AL). Issues have been discussed and a way forward will be proposed and discussed with ST and St George's Mental Health Trust. Update at next meeting.	**AL/ST/Niel Kenny**
5.	**New Drug Requests**	
a)	**Cacicol eye drops to promote epithelial healing**	

	Miss McElvanney explained that Poly-carboxymethylglucose sulphate eye drops are licensed as a medical device and belong to a family of bioengineered structural analogues of heparin sulphate glycosaminoglycans(HS GAG's) and are thought to mimic the functions of these ExtraCellular Matrix(ECM) components. ReGeneraTing Agents (RGTA) technology is the first therapeutic Matrix agent in ophthalmology and is used for the management of chronic corneal wound healing eg epithelial defects or neurotrophic keratitis. When applied to the wound RGTA's penetrate into the micro-clefts of the ECM and replace the endogenous HS that have been degraded by glycanases. The drops would be used where patients are refractory to conventional therapies and would otherwise require a more invasive or surgical procedure. They have a potential advantage against surgery which is high risk and carries a risk of infection and possible lifelong steroid therapy. The evidence is mainly from small non controlled studies which recognise treatment may be useful but efficacy remains to be proven in randomised controlled trials. There are also several individual case reports which were detailed for review by the committee. Level of evidence III-IV. Moorfields eye hospital in London is using these drops and so are several centres in Europe. As they are classed as medical devices they may not be detailed on hospital medicines formularies. They can be used in combination with steroid and antiviral eye drops. Miss McElvanney has used them in a few patients using the one off drug request process. The recommended dose is 1-2 drops in the affected eye once a week until complete re-epithelialization. The dose used has sometimes exceeded this but it was noted that more frequent use may compromise healing eg corneal scarring but Miss McElvanney advised this could be better than a perforated cornea. **Decision** The committee recognised that this is new technology in the field of regenerative medicine however due to the quality of and the limited evidence the committee rejected the application to add to the trust formulary. Existing patients will complete the course but no new patients are to be started. The committee recommended that the request be discussed with the Trusts innovation committee with respect to a research and development trial.	**AL/VSB/Miss McElvanney**
b)	**Azithromycin eye drops (Azyter 15mg/gm)** Azithromycin is a second generation macrolide antibiotic and in eye drop form is licensed for treatment of purulent bacterial conjunctivitis and trachomatous conjunctivitis caused by Chlamydia trachomatis (birth to adults). Miss McElvanney requested it be on formulary for 3 indications; bacterial conjunctivitis for patients unable to tolerate 1st/2nd line options such as chloramphenicol and quinolone drops; as an adjunct to oral treatment for Chlamydia conjunctivitis and for atypical mycobacterial keratitis infections. Dr Bendig advised the committee that for Chlamydia conjunctivitis it would be useful for all ages including neonates. Systemic treatment with a macrolide antibiotic is a recognised mainstay of treatment. The topical macrolides are an optional extra but he would support its use as currently we do not have a formulary option for this. The other topical option to use would be erythromycin eye ointment but this requires more frequent dosing and for a longer period of time (7 days versus 3). With regards to the treatment of atypical mycobacterial eye infection there does not appear to be any published evidence to support its use but it is recommended in Moorfields Eye Hospital guidelines which advise azithromycin as a second line agent to a combination of amikacin and levofloxacin. The trust formulary contains both first line agents. Dr Bendig had not been made aware of any cases where second line treatment had been required. **Decision** To add azithromycin eye drops 1.5% to the trust formulary for treatment of	**SA**

	purulent bacterial conjunctivitis and trachomatous conjunctivitis caused by Chlamydia trachomatis (birth to adults) in line with its licensed indication for use. Prescribing to remain in hospital. The committee did not support the use of azithromycin for atypical mycobacterial eye infection due to lack of evidence but first line agents, amikacin and levofloxacin drops remain available.	
c)	**Voriconazole eye drops 1%** Voriconazole is a triazole antifungal agent and it is available as an eye drop but is an unlicensed special. Miss McElvanney would like to use voriconazole as a second line-option to treat fungal keratitis. Filamentous fungi eg Fusarium and Aspergillus and yeast like fungi eg Candida are most commonly associated with keratitis. Fungal keratitis spreads rapidly and can lead to perforation of the cornea. Dr Bendig advised the committee that natamycin is also an unlicensed eye drop and this is considered the most effective agent against Fusarium and Aspergillus. Voriconazole is as effective at treating Candida. However Miss McElvanney advised that some patients do not respond to or tolerate natamycin and a second line agent is needed. Voriconazole is included in Moorfields Hospital Guidance - Natamycin is the empirical 1st line treatment for fungal keratitis with either amphoteracin or voriconazole if the infection is known to be caused by Candida. The samples are sent to the reference laboratory for culture which can take up to 6 weeks however local microscopy could provide information before these results are available. It was noted that voriconazole eye drops do contain preservative but Miss McElvanney advised that they would be used if other treatments were ineffective or not tolerated. **Decision** To add voriconazole 1% eye drops to the formulary as a joint second line agent for treating fungal keratitis due to Candida. Natamycin 5% eye drops remain first line for empiric treatment of fungal keratitis. Voriconazole 1% eye drops will be a second line agent once sensitivities are known and Candida infection confirmed and if the preservative can be tolerated. Amphoteracin eye drops remain available for second line treatment of fungal keratitis if preservative free drops are needed for Candida infection.	**SA**
d)	**Calcipotriol /betamethasone cutaneous (Enstilar)®foam** Dr Tewari advised that she was presenting this drug request on behalf of the whole dermatology team. Enstilar® contains a synthetic vitamin D3 analogue and a corticosteroid. This combination is already available on formulary as an ointment and gel (Dovobet® ointment and Dovobet ®Gel) but not foam for treatment of psoriasis. Psoriasis is a common genetically determined inflammatory and proliferative disorder of the skin. There is no cure and treatment is aimed at providing symptomatic relief and improved quality of life. NICE and SIGN guidelines are available for management of psoriasis and topical combination products with calcipotriol and betamethasone are recommended as first line topical agents to be used for flare up for trunk and limb psoriasis in adults, with emollients and vitamin D analogues , calcipotriol as maintenance therapy. When compared to Dovobet® gel, Enstilar® provided more effective plaque clearance and greater treatment effect and PASI 75 at week 4 than Dovobet® gel at week 8. When compared to Dovobet ® ointment, Enstilar ® had a greater treatment effect with significantly more patients achieving treatment success according to PGA at week 4. Significantly more patients using Enstilar® had treatment success at week 4 compared to the ingredients alone delivered in a foam formulation. Enstilar® was generally well tolerated over the 4 week treatment period. The foam spray is more cosmetically acceptable as the gel is drying on the skin and the ointment greasy. It also allows easier application to difficult to reach areas. Enstilar® does cost slightly more per 4 week course than Dovobet® gel or ointment and the	

	patents for these products runs out in 2021 and 2020 respectively. Dr Tewari then discussed the patient pathways for psoriasis patients and advised that it was felt that GP's could initiate this treatment prior to referring the patient to secondary care. There have been cases of systemic treatment failing and then the foam formulation of calcipotriol and betamethasone working. Surrey are currently reviewing their patient pathway for psoriasis and GP's from Sutton Merton and Surrey will be asked to consider the place in therapy of this agent. The committee felt it may be possible to remove some of the preparations from the formulary but that Dovobet ® gel with the scalp applicator may need to remain for management of scalp psoriasis. Decision The committee supported the decision clinically to add Enstilar® to the formulary for the treatment of psoriasis vulgaris in adults. However Dr Tewari to be asked to discuss with the consultant dermatologists the possibility of rationalising other preparations of calcipotriol and betamethasone. Primary care representatives to discuss with GP's patient pathways and initiation and maintenance of treatments including Enstilar® in primary care. Feedback at next meeting.	**SA**
e)	**Zerbaxa® (ceftolozane and tazobactam) injection** Zerbaxa ® is a cephalosporin and beta lactamase inhibitor licensed for the treatment of complicated urinary tract and intra abdominal infections. It has enhanced activity against gram negative organisms including pseudomonas aeruginosa and stable activity against many but not all beta lactamases. This application has been brought to the committee as a fast tract application in case the Trust is unable to obtain piperacillin /tazobactam due to a national supply shortage over the next month or so. There is also a potential shortage of meropenem and ceftazidime which may be used as alternatives to piperacillin and tazobactam in certain infections. It is considerably more expensive and will only be purchased if needed and on the advice of the microbiologists. This new combination agent also provides an alternative option for treatment of multi-resistant gram negative bacteria with increased potency against pseudomonas compared to ceftazidime and retains activity in the face of ESBL production and so an independent evaluation will be prepared and discussed at the next MMCBGM in January. Feedback at next meeting.	
	For Information	
f)	**Pivmecillinam** The request to add this to the Trust formulary was discussed at MMCBGM in November due to time pressures at NDAIG meeting in December. It is an antibiotic licensed in the UK for the treatment of infections due to mecillinam sensitive organisms such as urinary tract infections (UTI) and salmonellosis. It is recognised as an alternative first line option for UTI treatment in adults according to the public health England primary care antimicrobial guidance as there has been an increase in general resistance and community multi-resistant extended beta lactamase E coli with the use of other agents such as nitrofurantoin and trimethoprim. It will be used as an alternative first line agent for UTI's as determined by sensitivities. The microbiologists will only display sensitivity to pivmecillinam if it is an appropriate treatment choice as it is more expensive than most first line options. Therefore further microbiology approval will not be needed prior to initiation. **Decision** To add pivmecillinam to the Trust formulary for treatment of appropriate infections. Microbiology will only display sensitivity to pivmecillinam when it is an appropriate treatment choice.	**AL/Donna Francis**
g)	**Evolocumab**	

	NHS England has advised on the commissioning position for evolocumab for the treatment of homozygous familial hypercholesterolaemia. It will be available for patients aged 12 and over who meet the criteria and treatment should be stopped if there is less than a 30% drop in LDL-C concentration after 12 weeks of treatment. Only specified centres will be commissioned to prescribe and Trust patients will need to be referred to Royal Brompton and Harefield or Imperial College NHS Trusts.	**AL**
f)	**Tenofovir Alafenamde for HIV (**Odefsey® and Descovy® These combination products were discussed at the last meeting where it was advised they would only be available on a compassionate use basis. NHS England has now advised on their commissioning policy for these agents. The eligibility criteria for these agents Odefsey® (emtricitabine/TAF with rilpivirine 25mg) Descovy® (emtricitabine/TAF) and place in therapy are detailed in the commissioning document. Patients will be discussed at the relevant HIV MDT meeting. Trust formulary to be amended to reflect this policy.	**AL**
6.	**Six Month New Drug Reviews** Nothing for this meeting.	
7.	**NICE Guidance**	
	Updates	
a)	**Updated - Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease – TA217** Awaiting response from CCG's with regards to commissioning.	
b)	**Bronchiolitis in children – QS122** Awaiting response from Dr Kundu.	**Nashreen Maudarbacus**
c)	**Diabetes in children and young people – QS125** Awaiting response from Dr Kundu.	**Nashreen Maudarbacus**
	Technology Appraisals for Discussion	
f)	**TA413 – Elbasvir – grazoprevir for treating chronic hepatitis C** To be added to the Trust formulary for use by patients with genotype 1a 1b or 4 admitted already on treatment by the MDT networks.	**AL**
g)	**TA415 – Certolizumab pegol for treating rheumatoid arthritis after inadequate response to a TNF –alpha inhibitor** This Nice TA is being reviewed by the CCG's as this drug is currently excluded under the PbR process. Patient pathways for managing RA will be amended to reflect this Nice TA and the Trust rheumatologists have been involved in this process.	**AL**
h)	**TA416 –Osimertinib for treating locally advanced or metastatic EGFR T790M mutationpositive non –small cell lung cancer.** To be added to the Trust formulary for use by patients admitted already on treatment.	**AL**
i)	**TA417 – Nivolumab for previously treated advanced renal cell carcinoma.** To be added to the Trust formulary for use by patients admitted already on treatment.	**AL**
j)	**TA418- Dapagliflozin in triple therapy for treating type 2 diabetes.** Dapagliflozin is already on the trust formulary but it will now be available for use as part of triple therapy management of type 2 diabetes. Diabetologists are aware of the Nice TA.	**AL**
k)	**TA419 – Apremilast for treating moderate to severe plaque psoriasis.** To be added to the Trust formulary for use by patients who meet the criteria. It is excluded under the PbR scheme and funding will be via the CCG's following a BlueTeq application form. Dermatologists are aware of this process.	**AL**
	Technology Appraisals Not Recommended	
l)	**TA413 – Cobimetinib in combination with vemurafenib for treating unresectable or**	

	metastatic BRAF V600 mutation –positive melanoma Not recommended for use currently.	
	Clinical Guidelines Updated	
m)	**CG98 – Jaundice in newborn babies under 28 days (updated)** This guideline now advises revised tests for recognising neonatal jaundice, bilirubin thresholds for retesting and the type of phototherapy to use. It has been circulated for information to clinicians.	
n)	**CG95 - Chest pain of recent onset – assessment and diagnosis (updated)** Changes in this guideline include the use of high sensitivity troponin tests. Cardiologists are aware of this guidance.	
o)	**CG145 Spasticity in the under 19's : recognition and management (updated)** This guideline has been amended to reflect the WHO international classification of functioning disability and health.	
p)	**CG155 – Psychosis and schizophrenia in children and young people: recognition and management (updated)** This guideline has had a recommendation added on providing information on olanzapine when choosing antipsychotic medication with the first episode of psychosis.	
q)	**CG190 – Intrapartum care for healthy women and babies (updated)** The recommendations for ensuring continuity of care have been revised.	
	Clinical Guidelines (updated)	
r)	**NG18 – Diabetes (type 1 and 2) in children and young people: diagnosis and management (updated)** These guidelines have been amended to add information on when eye screening should begin.	
	Clinical Guidelines for information	
t)	**NG59 – Low back pain and sciatica in the over 16's : assessment and management** This guideline is for information only.	
	Quality Standard Updated	
	Nothing for this meeting	
	Quality Standard for Information	
u)	**QS133 – Children's attachment** These quality standards are for information and have no drug recommendations.	
v)	**QS135 Preterm labour and birth** These quality standards are for information and have been circulated to the clinicians.	
w)	**QS134 – Coeliac disease** These quality standards are for information.	
x)	**QS132 - Social care for older people with multiple long-term conditions** These quality standards are for information.	
	MHRA Guidance	
a) **b)**	**October 2016** **November 2016** The relevant sections of these alerts have been circulated to Trust clinicians.	
8.	**Patient Safety Alert**	
a)	**Risk of death and severe harm from error with injectable phenytoin** This PSA will be discussed at MMCBGM and an action plan devised. It was recognised that electronic prescribing of phenytoin will need to be reviewed to ensure that loading doses given in A+E are then transferred to the chart in a ward environment.	**AL**
b)	**Risk of severe harm and death due to withdrawing insulin from pen devices.**	**AD/VSB**

	This PSA is being addressed and a Medicines Matters Bulletin being devised.	
9.	**Operational Issues**	
a)	**3M Tegaderm IV securement dressing for central venous and arterial catheter insertion sites** Awaiting decision from Antibiotic Steering group at next meeting.	**AD**
b)	**Referral to Allergy Clinic** Dr Bansal has sent some references for the use of montelukast in allergy which will be reviewed and the discussed at the next meeting. The document written by the immunologists for GP's which includes information on when to refer patients to secondary care has been removed from the Trust internet until issues around the inclusion of unlicensed and non-formulary medications has been addressed.	**AL/VSB/SA**
c)	**Review of Trust Vitamin D Guidance** The Trust have had requests from both Sutton and Surrey CCG's to review its guidance and would like the guidance to cover the use in fractured neck of femur patients and use of the most appropriate higher strength preparations. The paediatricians are also interested in providing guidance for use in children. SP agreed to lead on this piece of work and a scoping meeting will be arranged.	**SP**
10.	**Feedback from CCGs and Trust Committees**	
a)	**Respiratory Working Group** The Trust arranged a further meeting of the Respiratory Working Group in November as agreed and CCG representatives attended. It was noted that there were 3 guidelines for management of COPD (Trust, Sutton CCG and Surrey PCN) however the differences were not clinically significant. There was discussion around the licensing and compatibility of spacer devices and the consensus was that as long as the spacer is compatible and fits then it should be considered suitable for use. However where possible and appropriate for the patient a spacer licensed for use with the inhaler should be used. SA to update the Trust poster with licensed and compatible spacer devices. It was felt that prescribing all inhalers including salbutamol by brand may be helpful. Sutton nor Trust clinicians supported the approach taken by Surrey PCN to have a 1st and 2nd line treatment choice highlighted but recognised the need to use the most cost effective option when choosing an inhaler for a patient. The group will now arrange a future meeting in the new year to discuss asthma management and this will include paediatric representatives. It was noted that the new BTS guidance for 2016 defines a place in therapy for Relvar and this inhaler for asthma use will be discussed at a future NDAIG meeting. Surrey Gp's /Pharmacists are using the High Dose Inhaled Corticosteroid Safety Card developed by the London Respiratory Network. The Trust and Sutton CCG community pharmacists issue the blue steroid treatment cards. The group agreed to look at the cost of the card and consider if the new card was the current standard of care. Update at next meeting.	**SA / AL**
b)	**DOAC's** **I. DVT/PE** The Trust have a patient pathway for confirmed VTE but are looking into options for unconfirmed cases and ensuring that guidelines are revised to reflect the process and treatment options available. Work is ongoing to create the initiation and checklist forms and transfer of care documents electronically to allow ease of completion and direct sending to GP's.	**AL**
c)	**SWL Sutton & Merton CCG's** **I. Minutes – September 2016**	

	For information. **II. South London Medicines Optimisation Programme** This Medicines Optimisation work stream is being led by the CCG but parts will involve secondary care eg waste and de prescribing. A report will be presented at the next meeting.	**AL**
d)	**<u>Surrey Prescribing Clinical Network</u>** **I. Minutes –October 2016** **II. Minutes –November 2016** Minutes for information. **III. Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia.** The Trust lipid specialists support this PCN statement. Prescribing will be initiated and continuation of treatment managed via the Blueteq database. **IV. Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia.** The Trust lipid specialists support this PCN statement. Prescribing will be initiated and continuation of treatment managed via the Blueteq database. **V. Ranibizumab (Lucentis®) for treating visual impairment caused by macular oedema secondary to branch or central vein occlusion** The Trust ophthalmologists support this statement which advises ranibizumab is a first line treatment option in this condition. **VI. Aflibercept (Eylea®) for treating visual impairment caused by macular oedema secondary to branch or central vein occlusion** The Trust ophthalmologists support this statement which advises aflibercept is a first line treatment option in this condition. **VII. Dexamethasone intravitreal implant (Ozurdex®) for the treatment of macular oedema secondary to retinal vein occlusion (branch and central)** The Trust ophthalmologists support this statement which advises dexamethasone intravitreal implant is a first line treatment option in this condition. **VIII. Hydroxychloroquine for the treatment of rheumatology and dermatology conditions.** The PCN have agreed to change the status of hydroxychloroquine for Rheumatoid Arthritis, Systemic Lupus Erythematosus and dermatology conditions caused by or aggravated by sunlight to Blue of their traffic light system. Initiation by specialist with a minimum of one month supply given. **IX. Dosulepin for the treatment of depression in adults.** This PCN recommendation is in line with Nice guidance which advises that dosulepin should not be initiated or patients switched to dosulepin for treatment of depression. Patients already on treatment will continue treatment until the clinician considers it appropriate to stop treatment. The Trust support this statement. **X. Dosulepin for treatment of neuropathic pain.** The PCN does not support the use of dosulepin for the treatment of neuropathic pain which is an off label use. Trust pain specialists in the trust support this recommendation. **XI. Ocular supplements for the prevention of age-related macular degeneration (wet AMD)** The PCN does not recommend the prescribing of ocular supplements in this condition and patients who are recommended to take these supplements can purchase these products over the counter from pharmacies. The Trust ophthalmologists have been advised of this recommendation. **XII. Bicalutamide for the treatment of prostate cancer**	

	The PCN have agreed to change the status of bicalutamide for the treatment of prostate cancer to Blue on their traffic light system. The initiating consultant should supply at least one month of medication and provide the GP with the monitoring requirements for the patient. Trust urologists are aware of this change. **XIII. Cyproterone for the treatment of prostate cancer** The PCN have agreed to change the status of cyproterone for the treatment of prostate cancer to Blue on their traffic light system. The initiating consultant should supply at least one month of medication and provide the GP with the monitoring requirements for the patient. Trust urologists are aware of this change. **XIV. Timolol maleate 1mg/g preservative gel (Tiopex®) for the reduction of elevated intraocular pressure in ocular hypertension or glaucoma.** The PCN recommends that the prescribing of this timolol preparation for patients requiring a preservative free treatment may be a more cost effective treatment option for some patients as an alternative to timolol preservative free single dose vials. The Trust do not currently have this option available on the formulary.	
e)	**<u>Shared Care Prescribing Guidelines</u>** **I. Sacubitril valsartan for the treatment of chronic heart failure in adult patients with a reduced ejection fraction.** The Trust have already agreed shared care for this drug with SWL CCG's and the Trust supported the communication to the GP's in SWL.(initiation checklist and transfer of prescribing forms). These forms have been replicated for Surrey patients and the trust cardiologists made aware of the process for initiating and transfer of this drug. **II. Rheumatoid Arthritis Biologic Drug Treatment Pathway.** The Trust rheumatologists support this treatment pathway.	
11.	**Any Other Business**	
a)	**Dates for 2017** The dates of next year's meetings are below: Wednesday 8th February 2017 12.30-2pm – Boardroom, Rowan House Epsom Hospital Wednesday 5th April 2017 12.30-2pm – St Helier Site (Room to be confirmed) Wednesday 14th June 2017 12.30-2pm - Boardroom, Rowan House Epsom Hospital Wednesday 9th August 2017 12.30-2pm – HR Room 5, HR Block, St Helier Hospital Wednesday 11th October 2017 12.30-2pm - Boardroom, Rowan House Epsom Hospital Wednesday 6th December 2017 12.30-2pm - HR Room 5, HR Block, St Helier Hospital	
12.	**Date of Next Meeting:** Wednesday 8th February 2017, 12.30-2.00pm, Boardroom Rowan House Epsom Hospital.	