Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

MOG 2017/03/001

Minutes of a Meeting of the AWP NHS Trust Medicines Optimisation Group (MOG)

Held on 15 December 2016, 1.30pm-3.30pm, Ash Room, Jenner House

These Minutes are presented for **Approval**

Members Present	
Rebecca Eastley, Chair (RE) Valerie McElhinney (VMc) Lucie Ralph (LR) Ellen Yankah (EY) Terri Turner (TT) Suzanne Webb (SW) Sophie Kellman (SK) Ray Gray (RG)	Maria-Paloma Sequeiros (M-PS) Prabhakaran Naveen (PN) Shirley Bickers (SB) James Severs (JS) Phil Harding (PH) Rebecca Spooner (RS) Sherin Mahany (SM) Ivan Nikolov (IN)
Staff In Attendance	
Christine Dean, Business Coordinator	
MOG/16/01 Apologies	
Chris May Debbie Campbell Kathryn Bundle Theresa Tattan	Jane Bolster Bill Bruce-Jones James Eldred Melanie Green

MOG/16/02 Declarations of Interest

None to declare

MOG/16/03 Minutes & Actions

Recorded as an accurate record

Action log amended.

30/6/16 MOG 16/21 POMH Audit Valproate Prescribing – ongoing; Jon Hayhurst, Bristol CCG to share findings with the group **Action: Update to be sent to the group via email. EY to follow up.**

20/10/16 MOG16/06 Methohexitone for ECT – ongoing; SB is working on a process whereby the drug is delivered to Hillview Lodge, where it will be stored securely until it is picked up by the ECT team.

20/10/16 MOG 16/05 Use of midazolam buccal for seizures. VMcE advised that this will require a new procedure, to be developed by the Resus Group. To be taken off action log and will be a MOG agenda item when ready for discussion/ratification.

Dates for 2017 meetings

The group discussed what day, time and venue would best suit members to ensure good attendance at the MOG meeting. It was agreed that the venue should be at Jenner House; CD to set up a doodle poll

and send to the members to identify the best day of the week to hold the meetings. The frequency of the meeting will be every other month. 2017 meetings will take place in February, April, June, August, October & December.

Action: CD to organise doodle poll.

002 Policies / Procedures / Guidelines

Rapid Tranquillisation Procedure

There was a discussion around what review period should be stated on the procedure. RE advised that the Trust is removing the standard review period from documents as it is not applicable. Should new guidance come out, then policies/procedures would need to be reviewed and updated immediately, and not wait for the review date. It was agreed that the procedure should be reviewed initially in one year and ongoing every two years, unless new guidance comes out. MOG to review the rapid tranquilisation procedure at the October 2017 meeting.

Section 5.2 'As required' (p.r.n) prescribing of medicines is included in the Rapid Tranquillisation procedure. The procedure discusses the possibility of exceeding the BNF maximum daily dose. RG asked for clarification on the wording in the procedure. The group advised that if in exceptional circumstances, the BNF maximum daily dose could be exceeded; this must be part of a plan to achieve an agreed therapeutic goal, under the supervision of a **consultant psychiatrist.**

The following point was also changed to read:
When rapid tranquillisation is being used, a doctor should review all the medication including regular and p.r.n. medication at least once a day, with support from a senior doctor as needed.
Link to Seclusion policy to be inserted.

Page 8 NICE Guideline NG10
RG raised two issues: The actual prescribing of Rapid Tranquillisation as a single dose and the practicalities of doing this, and secondly, where this should be prescribed on the drug chart. TT advised that on the 'once only' section of the drug chart there is *date/time* section to be completed by the prescriber; practice currently is to write the date on which the medicine is to be administered. If a time is also specified, this limits the nursing staff to administer the medicine at this time only. The Trust drug charts are not designed for this stipulation. Another option is to prescribe the medicine on the 'P.R.N' section of the chart. RE confirmed that this is only for the initial prescription. RG stated that the only way to resolve the difficulty is to design the drug chart to accommodate single dose Rapid Tranquillisation prescribing. A stop gap solution is being sought. RG suggested that guidance is made available to prescribers so that they know where/how to write the initial single dose on the chart; an example was shared. VMcE advised that some other Trusts have developed a separate supplementary chart for prescribing Rapid Tranquillisation.
Action VMcE & RG - Rapid Tranquillisation drug chart to be developed and circulated via email for discussion and ratified at the next meeting.

Inclusion of flumazenil guidance in the procedure (for emergency treatment of respiratory depression caused by administration of benzodiazepines)

It was confirmed that availability of flumazenil on units administering benzodiazepines is not specified in the new NICE guidance. JS stated that all emergency medicines available in the Trust are being reviewed by a newly formed group, in line with the Resuscitation Council's recommendations. JS felt that discussion about the inclusion of guidance on flumazenil, and availability of flumazenil on inpatient units should be had by this multidisciplinary group. He advised that this group would then bring their recommendations to MOG for discussion and ratification. The first meeting of this group will be on the 3rd February. RE asked for this group to submit its recommendations on flumazenil to MOG, however for the time being, flumazenil would remain stocked, and guidance on its administration would need included in the Rapid Tranquillisation procedure. RG suggested that the flumazenil guidance contained in the current Rapid Tranquillisation procedure be included in the revised procedure.

Page 13 - the group discussed if the procyclidine dose stated in the flow chart for older adults – over 65years, was correct: 5mg – 10mg. It was agreed to correct this to read 2.5mg – 5mg IM or oral.

Action: VMcE asked for the procedure to be sent out for peer review after the above changes have been made. Comments and feedback to be returned to RG by 15th January 2017.

Patients Own Drugs (POD) Procedure
The procedure sets out what the Trust is trying to achieve and describes responsibilities of different members of staff involved. EY highlighted that there is a check list which has been designed to help nurses assess the appropriateness of the medication.
Action EY to send to Jane Bolster for comment. Ratified pending JB's comments.

Olanzapine Long Acting Injection Procedure
VMcE advised that this procedure is a revision of an existing procedure discussing the specific monitoring required following administration of the injection. TT suggested that a link is created within the procedure, to the training available from the manufacturers, Lilly.
Action: EY to feedback to the document author to check that the post injection syndrome recommendations fit with Trust resuscitation guidance. This procedure must be consistent with the Trust Resuscitation Policy. Amendments to be made to the procedure then resubmitted to MOG for review at the February meeting.

Guidelines for the prescribing and administration of 'when required' psychotropic medication for inpatients
The group looked at the guidelines presented to the meeting. It was agreed that further work was required to bring it in line with the rapid tranquillisation procedure.
Action: EY to feedback to the document author. The guidelines should be simplified and resubmitted to MOG for review at the February meeting.

Non-formulary and Unlicensed Drugs Procedure
Pharmacy has looked at the process for requesting off-license and off-label medicines. If a medication is not licensed then a declaration from the consultant is required to confirm that they are aware that the medication they are requesting is off-license, but they want to use it.
The group was asked to comment and agree whether the statement in the procedure around liability within the Un-licensed and Off-Label Procedure was correct:

6.1. '*Any liability associated with the use of approved unlicensed medicines or medicines used* ***off-label*** *will be accepted by AWP providing that the prescriber has followed best practice as defined in this procedure* ***and supporting documents****.'*
The group agreed that the comment should remain in the procedure.

The trust has a list of approved off-label medicines. Pharmacy are proposing to add:
Clozapine augmentation – agreed
Atropine eye drops – agreed
Clozapine liquid – agreed
Pirenzepine – agreed

EY talked through the procedure and the request form. She highlighted that although this is a simple procedure; the correct process must be followed, including approval by the local Clinical Director, before it is submitted to the Medical Director and Chief Pharmacist. EY stated that the forms must have as much detail as possible to avoid delay. A section for 'consent to treat' has been added to the non-formulary drug/specialist use application form so that there are no additional forms to fill out when the drug being requested is unlicensed or to be used off-label.
Procedure Ratified

Prescribing for AWP service users in the community care setting
SB is working on the document and aims to have this completed for next MOG.
Action: SB to bring to February MOG

Controlled Drugs (CDs) Procedure
VMcE talked through suggested amendments to the current procedure:

- The current procedure makes reference to un-registered members of staff assisting with CDs. More detail around when it is appropriate to use un-registered staff, what they are able to do and what training is required will be added to the procedure.
- There was a change to Home Office guidance around destruction of schedule 4 CDs and these must now be destroyed by denaturing. VMcE stated that it would be good practice for a second healthcare professional to witness the denaturing and for this to be recorded. More specific guidance will be added to the procedure.
- A question was raised as to what happens if 'street drugs' come onto the wards. VMcE advised that 'unknown' substances are part of another procedure that is being worked on by pharmacist Ben Browning.
- VMcE mentioned that another issue around destruction of CDs is the amount sent to pharmacy for destruction, which may not be necessary to send. A piece of work is being carried out to determine which drugs can be destroyed at ward level and who can witness this destruction.

VMcE asked for the group to note the issue on the CD audit action plan around nurses checking CDs at every shift change. Feedback during the audit highlighted that this level of checking can be labor intense for nursing staff.
Action: VMcE to circulate the procedure to the group when further amendments have been made.

Trevicta (3 monthly paliperidone) Prescribing Bulletin
This item was an action from a previous MOG meeting. The bulletin has been produced to provide information on the use and administration of the drug. EY advised that unlike other long acting injections, the Trevicta vial needs to be shaken rigorously for at least 15 seconds before administration. A video link has been added to the bulletin for demonstration. Trevicta will only be available on request.
It was agreed that a copy of the bulletin advising on how to administer Trevicta should be sent with all dispensed Trevicta injections.
Approved – The bulletin will be uploaded to the Pharmacy page on Our Space.

Valproate Prescribing Bulletin
A one page summary bulletin advising on how to switch from Depakote to sodium valproate has been developed to help guide prescribers. This bulletin must be read in conjunction with the ratified valproate guideline.
Approved – The bulletin will be uploaded to the Pharmacy page on Our space.

Dr Naveen recommended purchasing leaflets from the DoH on contraception for patients on valproate.
Action Dr Naveen to arrange for the leaflets to be circulated.

MOG/16/12 – 003 Formulary Application

Oxazepam
Prescribing of oxazepam for alcohol detoxification in patients with severe liver impairment, managed on Acer Unit was discussed. It has been noted that there has been an increase in patients with poor physical health, and transfers of patients from the medical hospital who have commenced detoxification with oxazepam, due to their liver impairment. Chlordiazepoxide or diazepam is currently used for alcohol detoxification on Acer Unit. Caution is advised in treating those with severe liver impairment, and use of a shorter acting benzodiazepine such as oxazepam or lorazepam is recommended. Acer Unit supports the use of oxazepam in these instances due to the dosing similarities to chlordiazepoxide, a medicine that the ward staff is already very familiar with.

Discussion was had around the dosing schedules suggested, some of which exceeded the maximum BNF daily dose. IN raised 'symptom triggered dosing' for alcohol detoxification and discussed the potential advantages of using this.

Use of oxazepam was agreed in principle; however review of the dosing schedules was requested by VMcE.

EY advised that she had compared costs of the short acting benzodiazepines and oxazepam is cheaper than lorazepam.
Action: SK - Dosing schedules to be reviewed and presented to MOG for approval.

MOG/16/12 – 004 Cost Effectiveness

Paliperidone Reimbursement Scheme

SB advised that the pharmaceutical company Janssen had approached the pharmacy with two potential cost saving schemes on drug expenditure on paliperidone long acting injections - Xeplion and Trevicta.

SB advised that a number of NHS Trusts are being offered this scheme. This was brought to MOG for discussion and to decide if the Trust would like to sign up to the scheme and find out more about it.

A point was raised that if the Trust signed up for this scheme would it mean that it would have a declaration of interest?

Action: Further information required before a decision is made. SB/ VMcE will speak to other Trusts for further information.

Recommendations for Prescribing by AWP Prescribers Two bulletins were presented for discussion and approval (in-house prescribing and prescribing on FP10s).
EY asked the group to note that there are some drugs that the Trust could save money on, if some thought was given to how they were prescribed.

Drugs that would be cheaper include:
Quetiapine – immediate release should be considered before XL. EY advised that the current cost for example of the immediate release 300mg quetiapine daily is £0.05, whereas the XL would be £2.83.

Methylphenidate - within the Trust, it is cheaper to use Concerta XL than the new generic brands Xenidate XL and Matoride XL. EY asked that no generic products are used for in-patients.

Venlafaxine – guidance on prescribing venlafaxine detailed in the draft *in-house* guidance will be removed as the recent contract prices make the recommendation incorrect. A new contract has been implemented which gives the Trust a similar price for both the tablets and capsules. On an FP10 however, the tablets remain cheaper and should therefore be prescribed, not capsules.

Paliperidone – prior to paliperidone being released, risperidone was not given at the dose of 75mg-two weekly however, there seems to be a growing number of patients prescribed 150mg paliperidone. It is recommended that patients on the 150mg dose be regularly reviewed with the aim to maintain them on the minimum effective dose. A dose reduction from 150mg to 100mg monthly would save approximately £942 a year per patient.

Recommendations for Prescribing on FP10s Various drugs discussed. EY recommended prescribing on FP10, the generic methylphenidate XL brand Xenidate instead of Concerta XL, as it is cheaper in the community.

Pregabalin is more cost effective when prescribed BD rather than TDS. For example, reducing frequency from 100mg TDS to 150mg BD could save approximately £64 a month.

Action: Approved - bulletins to be sent to all prescribers for information and uploaded to Our space.

Therapeutic substitutions / stock holding rationalisation
EY presented a summary of the decisions that are being proposed:

- Calcium preparations – Adcal D3
- Doxazosin – plain tablets not XL
- 5alpha- reductase inhibitor – Finasteride. Dutasteride can be supplied on request.
- Iron – Ferrous sulphate tablets and ferrous fumarate liquid
- Prednisolone – plain tablets
- Quinine – Quinine sulphate 200mg
- Proton pump inhibitors – omeprazole capsules and lansoprazole capsules/ fastabs
- Paliperidone – long acting injection only. If oral required, use risperidone
- Methylphenidate XL – Concerta XL
- Melatonin - Circadin

EY advised that this initial list is for the group to agree. Existing stock will be exhausted with the view to

not re-order unless clinically necessary.

Approved.

MOG/16-12 / 005 Antimicrobial Stewardship

Antimicrobial Work Plan

The infection control and antimicrobial work plans are currently combined. It is the intention to separate these into two work plans.

Action 3.4 on the work plan: medical induction includes prudent antimicrobial use for all new medical staff - remains amber. Is the Trust doing enough on the Medical Induction in terms of antimicrobial training? SB advised that e-learning will be available throughout the Trust shortly.

Action: Antimicrobial prescribing to be added as a standing MOG agenda item.

SB advised that she had recently been on an antimicrobial course organised by Public Health England, about antimicrobial resistance and trying to encourage Acute Trusts, CCGs & Mental Health Trusts to work together.

Action: SB to update the work plan and present to the next MOG

Antimicrobial e-learning package (MLE)

VMcE advised that this is on the agenda for noting. It has been thoroughly peer reviewed and will be made available shortly.

Action: EY to discuss with Liz Bessant to agree which groups of staff should undertake this e-learning and how often it is to be completed.

MOG/16-12 / 006 NICE Updates

EY summarised relevant updates.

NICE are working on preparing a clinical guideline for the identification and management of mental health problems and integration of care for adults in contact with the Criminal Justice System. This is in the consultation process and is expected to be released around March 2017.

NICE is also preparing guidance on the management of medicines for patients receiving social care in the community.

MOG/16-12 / 007 Formulary Updates

Aripiprazole and Aripiprazole Long Acting Injections

EY showed a graph showing the Trust spend over the last three months compared to three other mental health trusts in the South West. AWP spent significantly more money on both paliperidone and aripiprazole injections, even when corrected for the number of beds.

A business case is being prepared to obtain the software Refine, which will help look at localities and teams prescribing patterns more specifically. When the software is received, reports will be shared at MOG.

EY advised the reason for the research was to consider whether paliperidone should remain formulary. A question was raised as to whether greater management of prescribing is required.

Action members of MOG to discuss at their local MAG/forum meeting and feedback comments to the next MOG meeting.

MOG/16-12 / 008 Feedback from the Medication Incident Review Group

A new way of working within the Medication Incident Review Group (MIRG) has begun, looking at themes and reviewing the incidents associated with these themes.

The first theme discussed was lithium. Eleven incidents in the past year were reported in the Trust. One of the things that the group will do is produce some learning from the meeting. Currently work is ongoing to review and update the lithium procedure.

Action: Submit revised lithium procedure to February MOG.

MOG/16-12 / 009 Clinical Audits

Alcohol Detoxification

The audit has been risk assessed as '15' - red.

A series of recommendations have been made by the data collector and consultant nurse. There are a number of actions which need to be implemented Trust-wide and LR asked how these could be implemented. It was suggested that a 'task and finish' group is set up to implement these. LR advised that Richard Edwards and Dr Janet Butler would be happy to be part of this group.

Some of the major issues highlighted in the audit report:

- Screening for Wernicke's encephalopathy on admission, including documentation of neurological examination
- Awareness of modifications to alcohol treatment for older adults
- How to improve breath alcohol measurement; is the right equipment available
- Promoting brief interventions
- Planning continuing care on discharge, referring to specialist NHS alcohol services

Action: LR to set up a group, to include Tim Williams and Richard Edwards, to look at the Trust guidance on alcohol withdrawal and the other recommendations. LR to ask JB for nurse input and RE for medical.

Non-Medical prescribing – to be circulated for virtual ratification

Pharmacy Interventions to be circulated for virtual ratification

Controlled Drugs – to be circulated for virtual ratification

MOG 16-12/ 10 Any Other Business

End of Life Medication

Dr Naveen – for noting had a patient who died on the ward. End of life medicines were supplied by the general hospital as these could be accessed more quickly. It was noted that Liz Bessant is doing work around End of Life Care.

MOG/16-12 / 11Dates of Future Meetings

7th March 1.30 – 4.30, SR3 Jenner House

25th May 9.30 – 12.30, Conference room, Jenner House

25th July 1.30 – 4.30, Conference room, Jenner House

26th September – 1.30 – 4.30, Conference room, Jenner House

28th November – 1.30 – 4.30, SR3 Jenner House