Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

Held on 7 March 2017, 1.30pm - 4.30pm, SR3, Jenner House

These Minutes are **Approved**

Members Present	
Rebecca Eastley, Chair (RE) Valerie McElhinney (VMc) Lucie Ralph (LR) Ellen Yankah (EY) Terri Turner (TT) Jeremy Wallace (JW)	Prabhakaran Naveen (PN) Ivan Nikolov (IN) Chris May (CM) Sarah Jones (SJ) Jane Bolster (JB) Christian Lee (CL)
Staff In Attendance	
Christine Dean, Business Coordinator	
Apologies	
Sherlie Arulanadam Shirley Bickers (SB) Bill Bruce-Jones James Severs	Jon Hayhurst Philip Harding

Declarations of Interest

None to declare

MOG 2017/03/001 Minutes from last meeting 15th December 2016

Recorded as an accurate record

MOG 2017/03/001 Action Log

MOG/16/26 Diagnosis and Prescribing Guidelines for Psychosis and Schizophrenia
NP advised that an AWP guideline on prescribing in first-episode psychosis is no longer required since NICE have published CG155 *Psychosis and schizophrenia in children and young people*. There still remains some uncertainty about how to best treat first-episode psychosis in an acute inpatient setting. RE suggested it would be timely to review the recommendations in NICE CG155.
Action: SJ & NP to review the NICE Guideline and bring a summary to the May meeting.

MOG/16/31 Insulin Doses for Diabetes – EY advised that a working group has been set up. Peter Arthure is the pharmacist liaising with the group.
Action: EY to contact the diabetes working group for an update on progress and report to the next MOG meeting

Sponsor: Chair

MOG16/06 Methohexitone for ECT – Update to be presented to the MOG meeting in May.

MOG 16/12/005 Antimicrobial e-learning– SB to complete the required form to allow learning and development team to put it on staff e-learning tree. To remain on action log until completed.

MOG 2017/03/002 Vitamin D Supplement

Christian Lee (CL) was invited to the group to discuss vitamin D supplement. CL advised that in May 2016 Public Health England set our guidelines around vitamin D, noting that the majority of people that fall into the service user category would need year round supplementation.
CL advised that most Trusts automatically prescribe vitamin D for service users. Data suggests that around 65% of people with schizophrenia have a vitamin D deficiency.
CL researched the various options around supplementation which can either be administered as a daily dose or monthly. The approximate cost for a daily dose per month is £2.95 vs £1.50 for the single monthly dose. The recommended dose is 10mcg per day (400 international units). RE asked if people are being asked to have routine blood tests for vitamin D. CL did not think this was required; it would be cheaper to supplement rather than take a blood test. On discharge GP follow up would be recommended. RE advised that she approves this recommendation in principle.

Actions:

- **CL and pharmacy to work together to find out what local Trusts are doing and to develop guidance for review at the May MOG. The cost of blood tests for vitamin D to be checked to see if it is cost effective to screen**.

MOG 2017/03/003Policies / Procedures / Guidelines

a. Polar Speed

A piece of work was carried out to see how many patients in the Trust receive medication from Polar Speed. The information from the sales report showed the following:
December 489 people
January 346 people
February 369 people.
SJ advised that the variation was due to stock management rather than patients.

The Homecare report (Hackett report), that came out 2011-12 advised that every prescription for Homecare needs to have a purchase order number. The AWP prescription form has been redesigned to be Hackett compliant and now includes a purchase order number. The new procedure describes the process: the prescription is written and goes to pharmacy for screening and input onto the pharmacy Ascribe system; the purchase order number is added to the prescription which will then be sent to Polar Speed by pharmacy, for dispensing; Polar Speed will then deliver the medication to the community team base. The procedure sets out the role of the prescriber, the pharmacy team and the staff in the community team.

The plan is to have a phased initiation on a team by team basis. EY confirmed that she has spoken to Polar Speed to advise them of the change of procedure and asked them not to accept any prescriptions that have not been screened and do not contain a purchase order number.

EY advised Polar Speed have granted the organisation permission to upload their forms onto the intranet.

JB raised a concern on the procedure 3.3 where it states that any discrepancy should be reported to Polar Speed. It needs to be made clearer so that changes are made with pharmacy.

Action EY to liaise with JB to make section in procedure clearer.

EY asked for everyone to let their areas know that a phased implementation will commence and the teams will be told when they are expected to use the new process.

JB asked who is printing the labels to be attached to reserve stock. EY confirmed that pharmacy will hold labels to be attached to reserve stock. JB requested that the procedure be amended to be more explicit that all labelling is to be done by pharmacy staff and not nurses.

Actions: VMcE to look at what other Trusts are doing. EY to liaise with JB to make section in procedure clearer.

Procedure approved subject to the above amendments.

b. Anaphylaxis Procedure Ongoing. It is to be circulated to the Resus group for comment before it is returned to MOG. **Action: JS**

c. PRN Guidance
RE mentioned that in section 9 – Monitoring, it mentions rating scales. RE was unsure whether in practice rating scales are always being used for anti-psychotics. RE asked for the wording to be amended to reflect use, as appropriate.
Approved

d. Physical Health Monitoring of Psychotropic Drugs – Ongoing - to be put on the May agenda. **Action: SB**

e. **Olanzapine LAI Guideline –** A discussion was had around the monitoring after an injection has been administered. Section 1.6 of the guideline states that post-injection monitoring must be undertaken for 3 hours. Currently this means the CPN would go onto the ward and sit with the patient for a period of 3 hours every fortnight. This time period is set by the manufacturer in the license for the product.

Approved

f. Lithium Procedure
RE asked the group if they felt it was over inclusive for the checklist to go to pharmacy. The discussion was had around leave and when a patient came back into the service. The form would need to be completed again. VMcE advised that as pharmacy do not always have access to blood test results, they need to see the checklist. SJ advised that when prescribing for a service user going on leave or discharge, the checklist would be required in pharmacy. IN asked if the form could be amended so that it is initialled when signing, i.e. remove tick. SJ mentioned that another way to enable access to the checklist by pharmacy would be to upload the checklist to RIO.
RE suggested that when a patient is initiated on lithium and/or admitted the first time, or it is prescribed in the community, a patient checklist is completed. If a patient is admitted to an in-patient unit, the checklist is re-visited. A question was asked that whether in the community the checklist, rather than being sent to pharmacy, could be uploaded to RIO. RE advised that if prescribing is not via an FP10, then the checklist should be sent to pharmacy.
A comment was raised on section 7.7 Lithium Toxicity. The guidance mentions levels of 1.2mmol/L or where there are signs of lithium toxicity. NP stated that often when lithium levels are close to 1.0mmol/L there is some anxiety about possible risk of toxicity.
Action: Paragraph to be added to explain that risk of toxicity should not only consider the level, but also the clinical presentation.

5.5 RE commented on the wording that service users taking lithum **must** carry a lithium card. RE asked that the word is changed to say the service users should be **encouraged to** carry a lithium card.

TT advised that there is a recognised NHS app available for monitoring lithium, rather than using the purple book.
Action: TT to liaise with lead author Sally Squire on the possibility of using the NHS app.

With the above mentioned amendments the guidance was approved.

CM advised that following a themed review of lithium issues in the Trust, in November 2016, a Safety Matters Briefing will link to the revised procedure.

g. Controlled Drug Procedure
TT raised the issue of training for certain unregistered members of staff who undertake a witnessing role for specific activities involving CDs (referred to as authorised witnesses). Not all nursing assistants would be sufficiently trained to pass the MLE CD module. JB commented

that the assistants are being asked to countersign not administer medication. VMcE advised that the procedure refers to the role of the authorised witness but does not specify what training the staff member should undertake prior to being authorised. VMcE advised that the procedure should be clear around the responsibilities of the nursing assistant so that there is no mis-understanding. JB advised that she would like to see a clear distinction of roles, as it is very different to a registered nurse role. JB advised that were a checklist in place to support the competency, this could be incorporated into the Care Certificate that un-registered staff are completing, which is part of the competency pack. Since training is referred to in the procedure, the details of this should be included as an appendix.
Actions JB to talk to Ben Padfield, Unregistered Practitioner Lead, to discuss the nursing assistant role. VMcE to send JB an example training checklist.

VMcE raised the issue around part used/spat out doses of medication and how they are destroyed on wards. The guidance from the Home Office advises that all controlled drugs in schedules 2, 3 and 4 (CD Benz POM) should be 'rendered irretrievable'. There was a discussion around the process and it was agreed that going forward destruction would be with soapy water. A record of the witnessed destruction must be kept for all schedule 2 and 3 CDs in the CD register. It was agreed that a designated 'Schedule 4 Destruction book' would be used for schedule 4 CDs.

A discussion was had around access to keys. The CD key and medicine cupboard keys are sometimes held by the same nurse. The CD key should be retained on a separate key ring and held separately to the medicine cupboard keys. The nurse who holds the key is the responsible person for that shift. If access is required to CDs, then that nurse should be the one to go to the cupboard. The CD key should not normally be handed over to another member of staff.

VMcE asked the group if the wording around access to digitally accessed key cupboards for the community teams is adequately covered in the procedure. A point was raised that if an OT was handed medication to return to the community team, how would they know if the pack contained CDs. CM advised that this has been raised in an incident previously, when the person returning medication left this on a desk not knowing that the pack contained CDs.
Action: VMcE to discuss with Nicola Hazle and Lisa Smith.

Checks of stock balances for all controlled drugs in the cupboard with all stock balances in the controlled drug register, completed by nurses at every shift change was discussed. JB advised that it is not providing additional assurance over daily checks. MOG agreed that a daily check should be carried out moving forward. JB advised that a record of the CD check should be in the CD register, on each page with a stock balance. It was suggested that the check is carried out in the morning handover to give time during the day to investigate and rectify any discrepancies. This would also give time for a discrepancy to be escalated if needed. JB requested that the escalation process when a discrepancy was discovered, be made clearer in the procedure.

A discussion was had around the balance adjustment considered acceptable by nurses for oral solutions of controlled drugs - 5% or 10%. MOG agreed that the limit of the permitted adjustment would be 5% of the volume stated on each original pack. RE emphasised that adjustments in excess of 5% must be reported via the incident system, as per procedure; under-reporting is suspected. If it is a regular problem then this will be discussed further at MOG.

Currently pharmacy staff check the CD register and CD balances monthly as part of a monthly audit. A recommendation has been made for the checks to be carried out every 3 months; more frequently if required. RE requested that the checks remain monthly, particularly as the nurse checks are being changed to once a day.

Matrons are meant to be completing checks on a monthly basis, but JB questioned whether these were routinely being completed. JB advised that part of the matron checks is to look at the CD register to ensure there are no discrepancies.
Action JB to take to the matrons meeting for discussion and report back to MOG

Action: VMcE and JB to make necessary amendments as per discussion and circulate to

the group for ratification.

CM advised that following a themed review of CD issues in the Trust, a Safety Matters Briefing will link to the revised procedure.

h. Rapid Tranquilisation Procedure

RE commented on:

- Patient Behaviour Safety Plan – Should this be revised with nursing staff.
- Prolonged QTc - further guidance on what is meant by this.
- Pre and post physical monitoring requires further information – concerns have been raised that patients are not getting pre and post checks which ties in with non-physical observations. JB advised that figures are dropping slightly in terms of recording. RE asked if that could be incorporated into procedure.

  A question was asked if an additional chart would be used, as discussed in previous meeting. SJ advised that if the decision was to design a new chart for rapid tranquilisation, it would further delay implementation of the procedure. There is an on-going debate as to whether there should be a separate chart. The option is that the method, as described in the procedure, could be tried and if it proves unsatisfactory, then pharmacy will look at this again. If a separate chart was to be used, it would need to be piloted first.

  A discussion around the wording that reads, 'if rapid tranquillisation is being used, a senior doctor should review all medication at least once a day' – does this mean that on a weekend this would be the duty of the consultant on-call to review the medication? The procedure does not specify that it has to be done on site, so this could be discussed over the phone.

  There was a discussion around reviewing re-admissions, and whether if a service user is known to the service and has had many admissions and many episodes of rapid tranqillisation, should that make a difference. RE advised that it is safer to have one standard recommendation for all.

  SJ raised a point that is not in the procedure but is specifically recommended in the NICE guidelines, i.e. the Service User Experience Monitoring unit or equivalent service user group should undertake a formal external post incident review as soon as possible, and no later than 72 hours after the incident. NP advised that if a patient was treated over the weekend, then someone who is not part of the ward team needs to review and to ensure that the correct procedure was followed. SJ raised this so that the group is aware that AWP are not meeting this recommendation in the guidance. RE explained that as it is guidance, it is not compulsory, so the Trust are not failing on compliance.

  JB advised that further work is needed on the behaviour support plan.
  Actions: JB to make amendments to reflect this in procedure.

  Action: Once all the amendments are made the procedure will be circulated to the group for electronic ratification.

i. Naloxone PGD

Review ongoing. To be presented at the May meeting.

j. Medicines Information Bulletin: Hyoscine hydrobromide (Kwells) - supply problems

Bulletin sent to the group for noting. EY advised that some information has been received about stock coming in, but it is not enough to sustain supplies. Pharmacy will keep guidance as it is until a further sustainable solution is found.

k. Hepatitis B vaccine and Naloxone PGDs - extension of expiry

VMcE advised that both PGDs have been reviewed and can continue to be used until the revised versions are ratified. Extensions agreed until end May 2017.
Action: Revised PGDs to be reviewed at the May MOG.

l. Flu vaccine product report

VMcE advised that a review of all the flu vaccine preparations on the market had taken place. SB has provided a summary report which is available should anyone wish to see it. EY advised that there is a deadline for ordering and orders needed to be placed in next week.

Action: RE and VMcE to agree which preparation is to be purchased by the Trust. The group will then be informed of the decision. Retrospective ratification.

MOG 2017/03/004 Formulary Application

No applications received.

EY advised that at the last meeting, the application for oxazepam to be added to the formulary needed more work on the dosing schedules. Response from the team who made the application is still pending.

EY raised the issue of sodium valproate which has been discussed at previous MOGs. There had been some concerns raised by CCGs about availability of a licenced preparation and AWP prescribing 'off label' (for mania). The Episenta brand is sodium valproate modified release and is licenced for the same indications as Depakote (semi-sodium valproate). The prices are comparable; the only issues are that it comes as capsules and is only available as modified release in 150mg multiples. Prescribers would need to be aware of the strengths and dose accordingly. EY asked if we would like to use this brand instead in the Trust.

RE advised that no change is to be made.

MOG 2017/03/005 Cost Effectiveness

a. Biquelle XL (quetiapine) on FP10s

EY advised that Ebesque XL (quetiapine) is no longer available. After some research it was found that Biquelle brand is available in the same strengths as Ebesque and at comparable costs, guaranteed until 2018. A prescriber bulletin has been produced to let primary care colleagues know that Biquelle is now our approved brand. EY asked for approval before circulation. A query was raised about whether to mention that the immediate release preparation can be given once per day. EY advised that she will check the wording received from the manufacturer however RE advised she was happy not to specifically include this information in the bulletin. **Approved for circulation**

b. Long acting antipsychotic injections expenditure reports

SJ advised that pharmacy has access to new software allowing more thorough investigation of the drug spend. She presented data on the expenditure on long-acting antipsychotic injections which are a big pressure on the drug budget. Paliperidone, aripiprazole and risperidone long-acting injections all feature in our top ten high-cost drugs. Benchmarking against other trusts (even adjusting for trust size) indicates we are relatively high users of the newer long-acting antipsychotic injections.

The trust needs to decide if it wants to take action on this data. We could perhaps be more proactive in following-up individuals started on these medicines to see what factors predict a successful outcome. However there is limited pharmacy or medical capacity for this type of work. TT commented she does locally track those stopping these injections and that aripiprazole is discontinued more frequently than aripiprazole.

RE asked about the evidence bas of aripiprazole against paliperidone. NP commented that paliperidone has an advantage due to the loading dose, meaning people can reach therapeutic drug levels quicker, leading to quicker inpatient discharge.

Various formulary options were discussed:

- Taking all second generation long acting antipsychotics off the formulary
- Putting both aripiprazole and paliperidone on the formulary with local approval procedures
- Aripiprazole is put on the formulary for use by early-intervention teams/first episode psychosis only

IN put forward a request for aripiprazole long acting injection to be put on the formulary.

The meeting decided that in the short-term **aripiprazole would remain non-formulary** and **paliperidone would become non-formulary**. However it would be helpful for an MDT group with nursing, medical and pharmacy representation to thoroughly review the evidence and share clinical experience to suggest a trust protocol for the use of these expensive drugs.

MOG 2017/03/006 Antimicrobial Resistance (AR)

Antimicrobial Work Plan - To be presented at the May meeting. **Action: SB**

MOG 2017/03/007 Nice Updates

EY advised that in January NICE published a Quality Standard around people with learning disabilities and the fact that they need to have a mental health assessment annually as part of their care. It is available and on the NICE website, Quality Standard 122.

NICE has provided a Quality Standard for Care of Dying in Adults. – for information

National guidance 64 on drug misuse prevention, targeting interventions for people who are likely to misuse drugs.

Key Therapeutic Topic 7 - Updated guidance on the use of antipsychotics for people with dementia

NP advised that updates may be accessed via 'MentalElf,' available through ISOS devices.

MOG 2017/03/008 Formulary Update

The attached table shows how many requests have been approved May 2016- to date.

	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-17	Feb-17
Aripiprazole LAI	2	4	4	8	3	6	6	4	3	3
Pirenzepine	2	1	0	0	0	0	1	0	0	0
Lurasidone	2	0	0	2	0	0	1	0	3	1
Agomelatine	1	0	1	1	1	0	0	0	0	0
Cyproterone	2	1	0	0	0	0	0	0	0	0
Fluphenazine 100mg/ml injection	0	3	0	0	0	0	0	0	0	0
Trihexyphenidyl	0	1	0	1	0	2	0	0	0	0
Olanzapine	0	0	1	1	0	0	0	0	0	0
Paliperidone	0	0	0	1	0	0	0	0	0	0
Levomepromazine	0	0	0	0	1	0	1	1	1	0
Asenapine	0	0	0	0	0	1	0	0	0	0
Prazosin	0	0	0	0	0	0	1	0	0	0
Naltrexone	0	0	0	0	0	0	0	0	1	0
Dosulepin	0	0	0	0	0	0	0	0	0	1

RE requested that an update is presented to each MOG.

MOG 2017/03/009 Feedback from Medication Incident Review Group

Safety Matters Briefing – Learning from medication incidents

CM presented the latest Safety Matters Briefing – learning from medication incidents, which has been approved and issued in the Trust, discussing consent to treatment. The bulletin was presented to MOG for noting.

The MIRG looks at relevant audit results, incidents, particularly any serious incidents, and information from complaints and surveys and pulls all the information together to see what themes emerge and what learning can be taken from it. A bulletin is then prepared to inform staff of the issues found, learning and recommendations. CM advised that the team are currently working on lithium, controlled drugs and missed doses. The next topic will be clozapine.

RE advised that Mark Dean suggested that a bulletin is developed around the learning from incidents, which is then uploaded to MLE. This would give the Trust the assurance that learning from incidents is being read.

Action: CM to discuss with Mark Dean

MOG 2017/03/101 Audits

a. POMH Alcohol detoxification

Janet Butler, Richard Edwards and Sue Leaman provided feedback into the action plan for this audit

and have scored the findings as a, 15 RED. MOG were asked to agree that the score of 15 is representative of the risks. The audit will be presented to the Audit & Risk Committee.

The issues raised in the audit report were around prescribing of thiamine IM, (Pabrinex) and screening for Wernicke's.

The actions relating to the findings were discussed. There were actions around management of people in the S136 suite. Though it was not part of the audit, it was noted that some of the service users started experiencing symptoms of alcohol withdrawal whilst in the S136 suite, waiting for a bed. Availability of suitable guidance on management of alcohol withdrawal in the S136 suite needed checked.

There were some actions around the guidance currently in use in the Trust and some revision is taking place relating to the need to prescribe IM thiamine for all inpatients treated for alcohol withdrawal, and signposting within the guidance.

There was a request for the updated guidance to be discussed at local academic meetings.

Measurement of breath alcohol is not being completed. It was originally thought this was because all areas do not have access to the equipment; however pharmacy confirmed that there are alcohol meters on the wards. It needs to be understood why clinical staff are not doing the testing when equipment is available.

RE stated that the risk rating is higher than expected for this audit. RE advised that the score should change to **12 Red.**

Action: LR to check with Dr Tim Williams that he would be happy for MOG to approve the audit report. Approved subject to comments from Dr Tim Williams.

Action: When the audit has been approved by Dr Tim Williams, it will be circulated to the medical leads for forward circulation to the consultants, to be discussed in supervision with their trainees and junior doctors.

VMcE advised that the Junior Doctor Induction booklet should come to MOG for ratification.

b. Medicines Audit Schedule

LR advised that the updated schedule was for noting, showing the upcoming audits throughout 2017-18.

MOG 2017.03.011Any Other Business

a. Methohexitone for ECT report – outstanding. **Action: SB**

b. CMHT Prescribing issues SBAR

TT explained that the SBAR describes prescribing issues at Chatsworth House, a base for recovery and EI in Swindon, with approximately 800 service users in their care at any one time. Historically Swindon has had particular problems with GPs taking on prescribing from mental health services. With the current shortage of GPs in Swindon, these problems are not improving. There has been an agreement with the CCG for PCLS to prescribe using FP10s which will be costed to the CCG , to help with this situation.

TT explained that the pathway in Swindon is very much towards AWP prescribing mental health drugs. Conversations have been had with the CCG in which the CCG have explained that GPs cannot be forced to take on the prescribing. Historically Swindon had a huge FP10 use. Prescribing and supply was moved in-house, in 2015. This is now causing pressure on the Trust pharmacy service due to the large volume of prescriptions; over 500 items were dispensed in one month.

TT explained that an audit was carried out on a month's worth of prescriptions. There were 93 service users with 13 of those on non-formulary items, which could not be transferred to the GP and some were on a combination of formulary /non-formulary medicines. Thirty two service users were prescribed a benzodiazepine or Z drug. The mental health lead GP in Swindon advised that according to NICE guidelines such drugs should not be prescribed for more than four weeks. He has taken a lead with his surgery and will not take anyone back on benzodiazepines.

RE advised that she will discuss this situation with the Quality Sub Group; just because GPs will not prescribe for their patients, does not mean that AWP have to.

TT advised that most of the prescriptions reviewed in the audit were transition prescriptions, not stable prescriptions. Four people were doing three month initiation of shared care on lithium. They would be transferred to the GP once stabilised. Sixteen patients have been followed up since and have had their prescriptions transferred back to the GP; the switch has been completed satisfactorily. There were a few patients who either pay for their prescriptions or refuse to have them dispensed if they have to pay for them.

The plan is that pharmacy will meet with the consultants and team managers to see what can be prescribed on FP10s to relieve some of the pressure on pharmacy.

The report was presented to the MOG for noting.

MOG/16-12 / 11Dates of Future Meetings

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