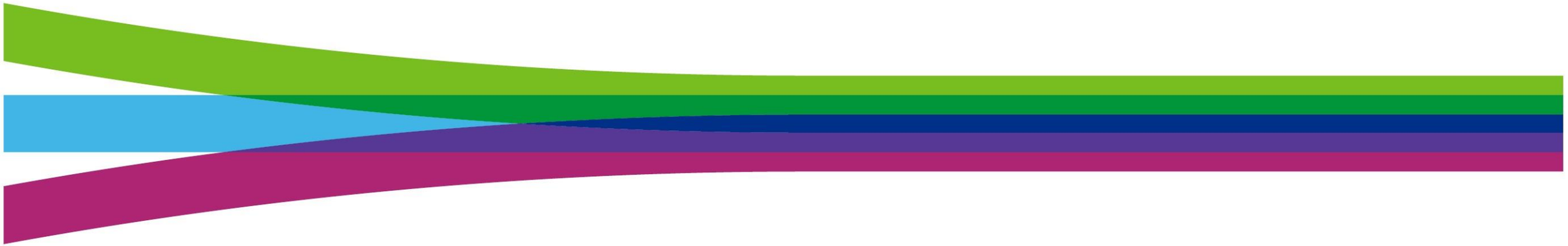
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

Overview: Reducing Inappropriate Prescribing of Dependence Forming Medicines

Collaboration on Medicines Optimisation 2020-21

Lucy Lightfoot BSW CCG Meds Opt Pharmacist October 2020



Agenda

- Dependence Forming Medicines (DFM) - Definition & Classes of Medicines?
- Background - PHE Evidence Review Sept 2019
- PCN data and benchmarking
- BSW CCG Medicines Optimisation team - reducing inappropriate prescribing of DFMs across the system
- PCN Network Contract DES. Meds Opt and SMR specification - DFM
- Where to start?
- Resources

Dependence Forming Medicines (DFM) - Definition & Classes of Medicines?

- Dependence in this case is defined as the need to continue taking a medicine to maintain a state of normality and avoid symptoms of withdrawal*
- Opioids
- Gabapentinoids (Pregabalin and gabapentin)
- Benzodiazepines and Z-drugs
- Treat these classes of medicines as you would any other ‘high risk’ medicine
- N:B Antidepressants, not addictive but can be associated with withdrawal symptoms. Not classed as DFM but require support for withdrawal.

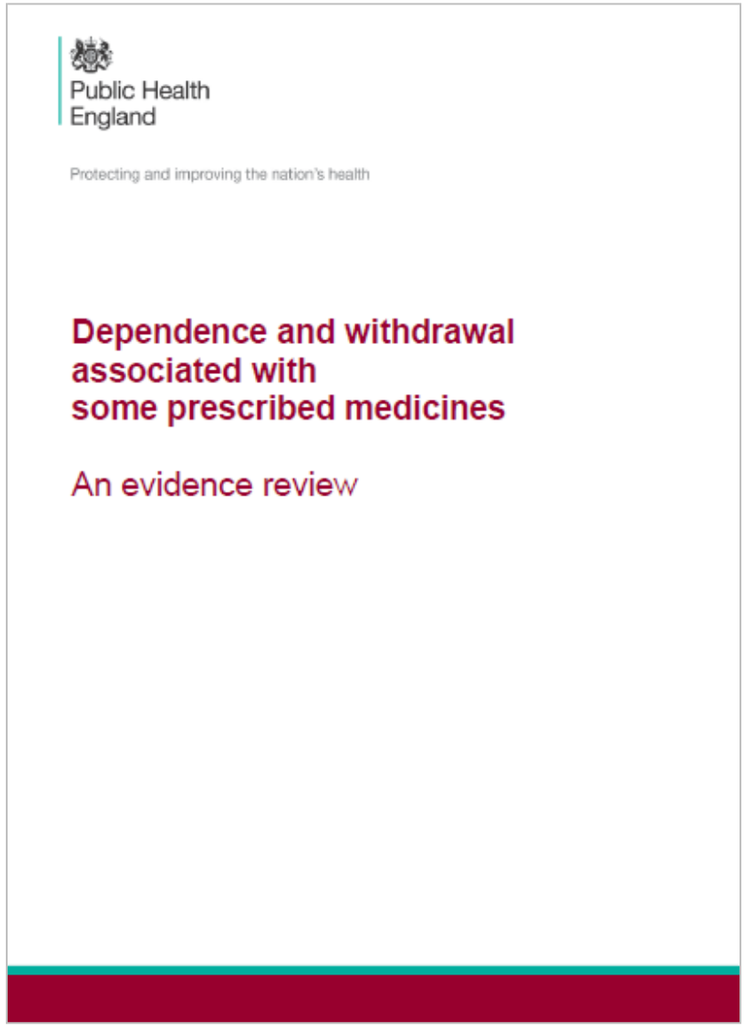
*Public Health Consortium definition

PHE Evidence Review Sept 2019

- Of the adult population in England the proportions receiving one or more prescriptions in 12 months (2017-18) were:
  - opioid pain medicines 5.6 million (13%) (excl. cancer pain)
  - gabapentinoids 1.5 million (3%)
  - benzodiazepines 1.4 million (3%)
  - Z-drugs 1.0 million (2%)
- Large variation in standardised prescribing across CCGs
- Prescribing rates for opioids and gabapentinoids had a strong association with deprivation, being higher in areas of greater deprivation

https://www.gov.uk/government/publications/prescribed-medicines-review-report

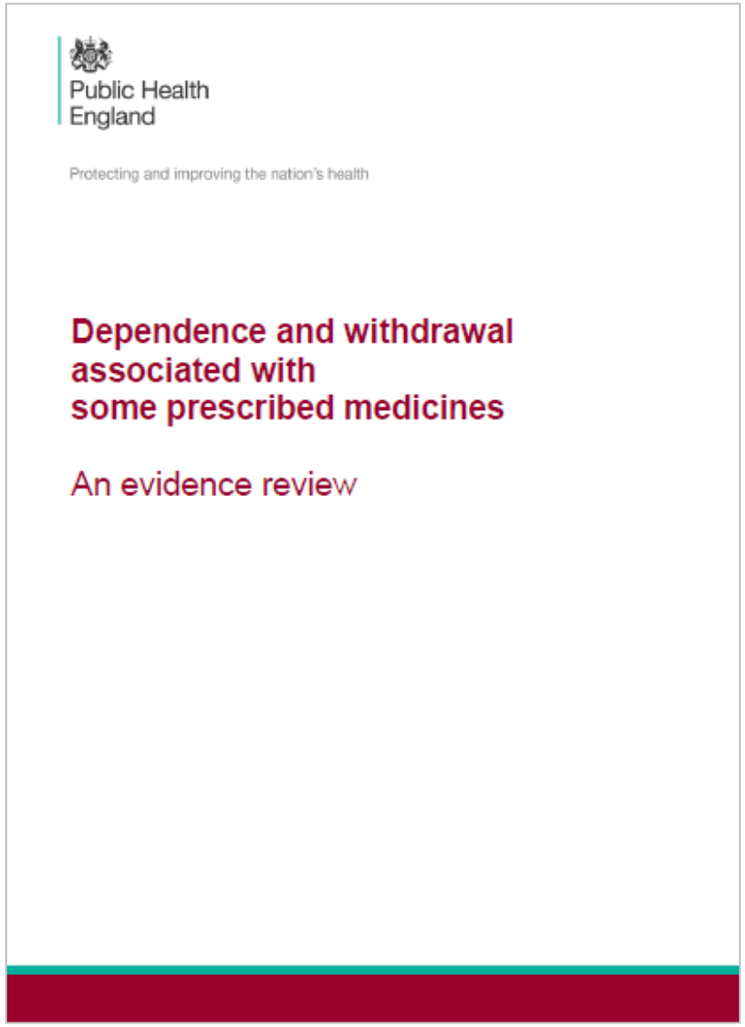
PHE Evidence Review Sept 2019



Patients' experiences

- Reported harmful effects and withdrawal symptoms on stopping affecting their wellbeing, personal, social and occupational functioning for many months.
- Experienced barriers to accessing and engaging in treatment services. They felt there was a lack of information on the risks of medication and that doctors did not acknowledge or recognise withdrawal symptoms.
- Described not being offered any non-medicinal treatment options, their treatment not being reviewed sufficiently and a lack of access to effective management and NHS support services.

PHE Evidence Review Sept 2019



- Reports gave a series of recommendations
- The goal is to make sure that our healthcare system builds awareness and enhanced decision-making for better patient treatment and support.
- All parts of the healthcare system and the general population will need to engage with this complex problem and work together to find solutions. The local strategic leadership of CCGs, sustainability and transformation partnerships and integrated care systems will be vital

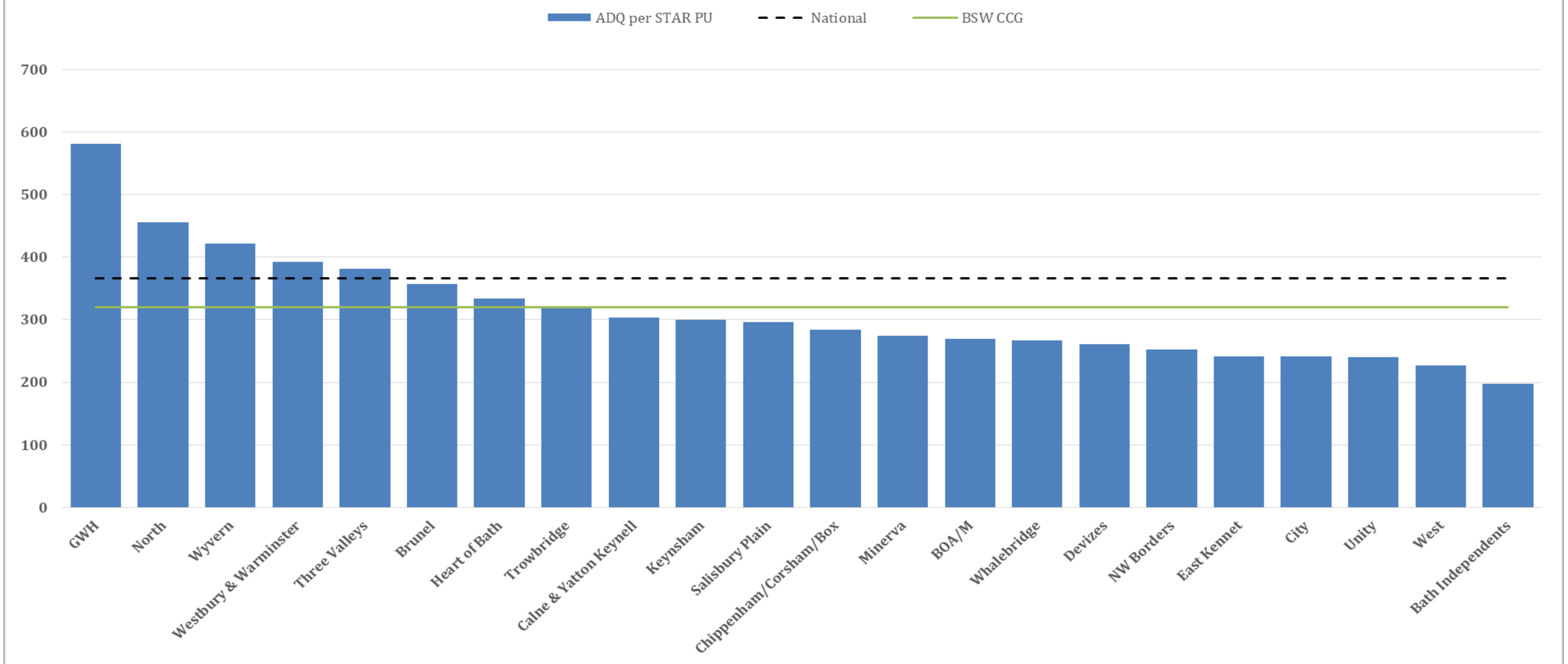
- https://www.gov.uk/government/publications/prescribed-medicines-review-report

Public Health England

Prescription Medicines Review: Recommendations

- Give NHS commissioners and doctors **better insight into prescribing data**
- Update **clinical guidance** on these five classes of medicines
- **Improving training** for clinicians to ensure their prescribing adheres to best practice
- New clinical guidance on **safe management** of dependence and withdrawal
- **Better information to patients** about the benefits and risks
- Doctors have **clear discussions with patients** including on social prescribing alternatives
- **Support made available locally** for patients with problems
- A **national helpline** for patients to be set up
- More **high-quality research** is undertaken

Pain - Strong and Weak Opiates ADQ per 1000 STAR PU - PCN

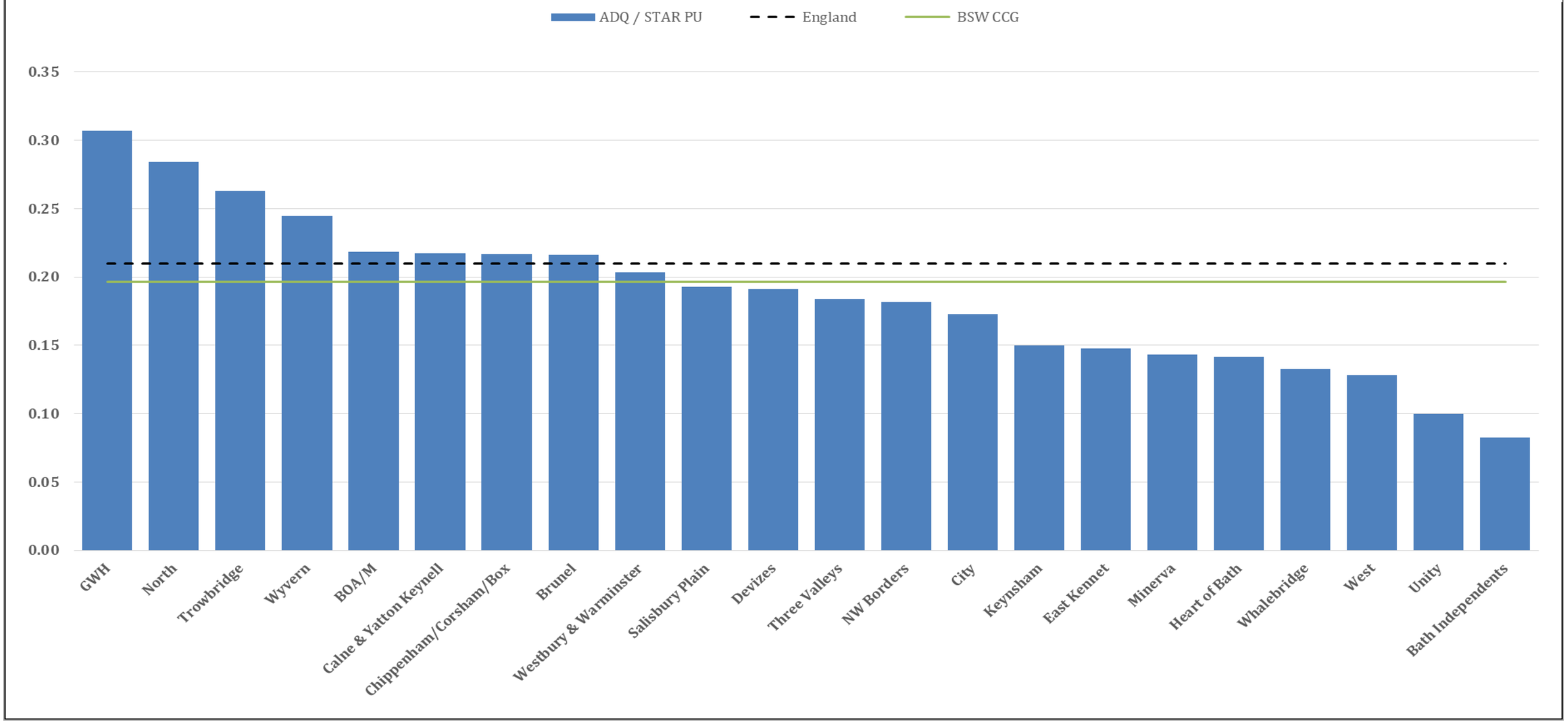


Back to Dashboard

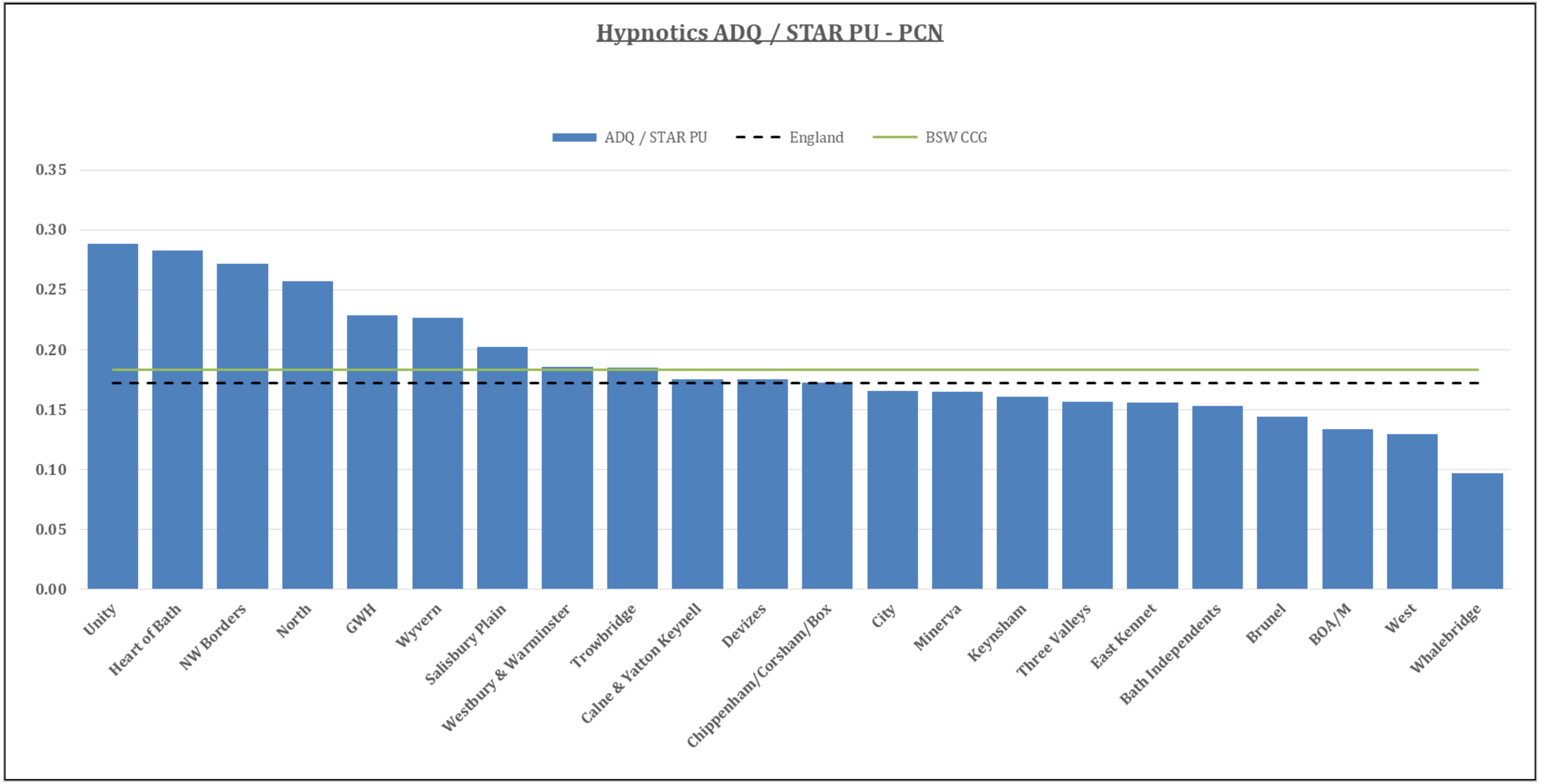
Gabapentin and Pregablin ADQ per STAR PU

Q1 20/21 (Apr - Jun 20)

NHS
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group



Hypnotics ADQ / STAR PU - PCN



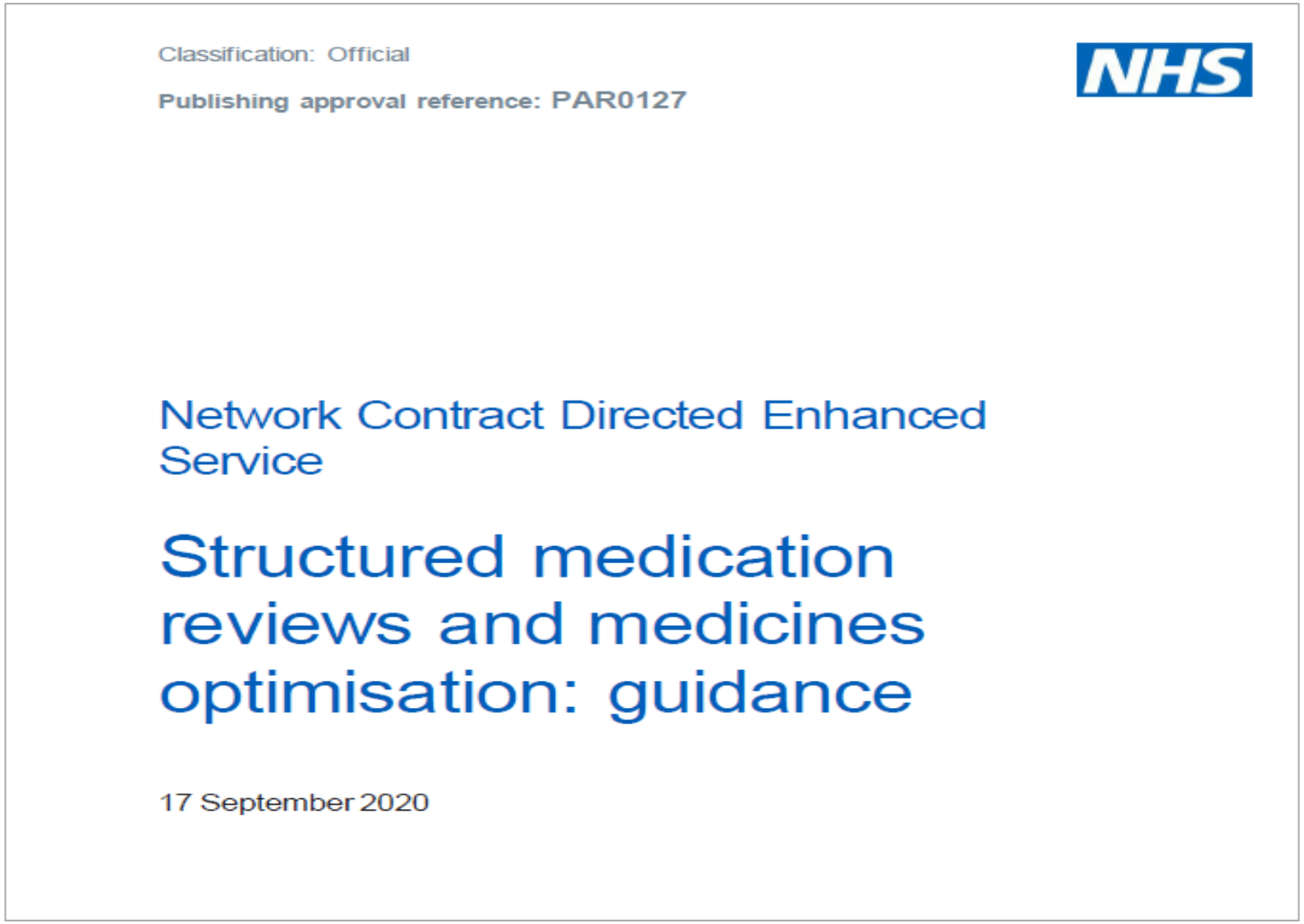
BSW CCG Medicines Optimisation team - reducing inappropriate prescribing of DFMs across the system

- Recognition historic/chronic prescribing based on old guidance not necessarily poor practice.
- How can the healthcare system work together to reduce inappropriate prescribing of DFMs?
- Scoping/Mapping - Where within our system clinical pathways/services?
- Engaging with relevant stakeholders across the system to establish requirements: PCNs, pain services, MSK work-streams, acute trusts, local substance misuse services, CDAO, patient groups
- Collaborative approach. Shared goals.
- Feedback from PCNs/GP practices on issues that require a solution at system

BSW CCG Medicines Optimisation team - reducing inappropriate prescribing of DFMs across the system

- Links with other systems – What is working elsewhere?
- Data & audit
- Establish requirements to facilitate reduction in inappropriate prescribing of DFMs:
  - Joint/integrated guidance across pathways, improving communication re. medicines at care interfaces, support, feedback, networks, signposting to resources/support
- Support local education for clinicians - Lead Pain Clinicians networks e.g. Swindon Pain Champions - PCNs
- Links to strategic Medicines Safety plans/groups

PCN Network Contract DES. Meds Opt and SMR specification



Classification: Official

Publishing approval reference: PAR0127

Network Contract Directed Enhanced Service

Structured medication reviews and medicines optimisation: guidance

17 September 2020

PCN Network Contract DES. Meds Opt and SMR specification – DFM

Service requirement 1: Identification of patients

3.1 From 1 October 2020, each PCN must use appropriate tools to identify and prioritise patients who would benefit from a SMR, which must include those:

a. in care homes
b. with complex and problematic polypharmacy, specifically those on 10 or more medications
c. on medicines commonly associated with medication errors[10]
d. with severe frailty,[11] who are particularly isolated or housebound or who have
e. using potentially addictive pain management medication.

PCN Network Contract DES. Meds Opt and SMR specification - DFM

Service requirement 6: Collaboration on wider medicines optimisation

3.22 The NHS Long Term Plan sets out the aims for medicines optimisation to reduce inappropriate prescribing of (a) antimicrobials, (b) medicines that can cause dependency, (c) higher-carbon inhalers and (d) nationally identified medicines of low priority. To help achieve these outcomes longer-term, PCNs must actively work with their CCG and at ICS/STP level, to share expertise and lessons learned: for example, to integrate national-level programmes, such as the AMR action plan[20] and STOMP (stopping over medication of people with a learning disability, autism or both with psychotropic medicines)[21] set out in the Long Term Plan, into their local implementation of SMRs, medicines optimisation and related work. Open data, eg OpenPrescribing,[22] can further support this work.

PCN Network Contract DES. Meds Opt and SMR specification - DFM

- PCNs still developing, unprecedented challenges, current pandemic
- CCG to collaborate and support PCNs
- Focus on target priority group, quality not quantity
- Not a prescriptive CCG incentive scheme type project
- PCN lead Meds Opt project
- Measured by Network contract DES dashboard ?Metrics?

- https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation/

Where to start?

- Be realistic, small steps
- Understand your data, benchmark - national & local:

  Data sources: https://openprescribing.net/ https://www.prescqipp.info/
  Clinical System Searches, Arden's standard reports/searches
  BSW CCG Meds Opt dashboard

- Education/learning – significant events, case studies, e-learning, Education and Resources. What are the learning needs/current competence re. DFM?
- Examples of best practice from other areas https://www.prescqipp.info/community-resources/innovation-and-best-practice/highly-commended-gp-and-practice-clinical-pharmacist-opiate-reduction-clinic-project-2018/
- Reflect on quality improvement (QI) principles https://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx

Where to start?

- **Audit.** Two pronged. Best practice for managing new initiations (acute prescribing) and existing chronic prescribing (repeat prescribing). Prescribing over 8-12 week period. https://www.cochrane.org/CD000259/EPOC_audit-and-feedback-effects-on-professional-practice-and-patient-outcomes

- **Present findings** at a practice clinical meeting, verbal and written summary of results. Discuss and agree together a way forward. Clear targets and action plan. Medicolegal considerations.

- **Whole team approach** (including admin, prescription clerks etc.) Include in practice repeat prescribing/medicines policy. Consistent, avoid good cop bad cop scenarios. Identify lead clinician.

- **Clinical system templates** to prompt clinician to follow best practice and document key discussions e.g. indication, review/follow up plan, patient information about risks of tolerance, addiction and accidental overdose, recording morphine daily equivalent

Where to start?

Suggestions/consider:

- Is there a clear indication for DFM recorded in the clinical notes?
- Is there a record of the total morphine daily dose equivalent, including where multiple opioids are prescribed?
- Is there a record of discussion around risk and benefits, risk of addiction/dependence. Opioids, risk of overdose (including accidental)?
- What patient information is supplied & signposting to resources?
- Recorded evidence of shared decision making, treatment aims/plan and regular follow up to review aims?
- In chronic use, is there a recorded discussion of offer of support to withdrawal?

Where to start?

- Require support and collaboration to develop competence and practise safely
- Prioritise patients at highest risk of harm & who are willing to engage.
- Start to identify potential priority groups:
  - High dose opioid prescribing 120mg Morphine equivalent or above (significant increased risk of harm with no increased benefit). Note: calculated morph eq. where multiple opioids prescribed https://www.paindata.org/calculator.php
  - Opioids in combination with gabapentinoids (gabapentinoids reverse tolerance to opioids and potentiate their effects)
  - Combination of 3 or more DFM (Opioid(s), gabapentinoid and benzodiazepine/z-drugs)

Opioids Aware – Faculty of Pain Medicine

Key Messages

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.

2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.

4. If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

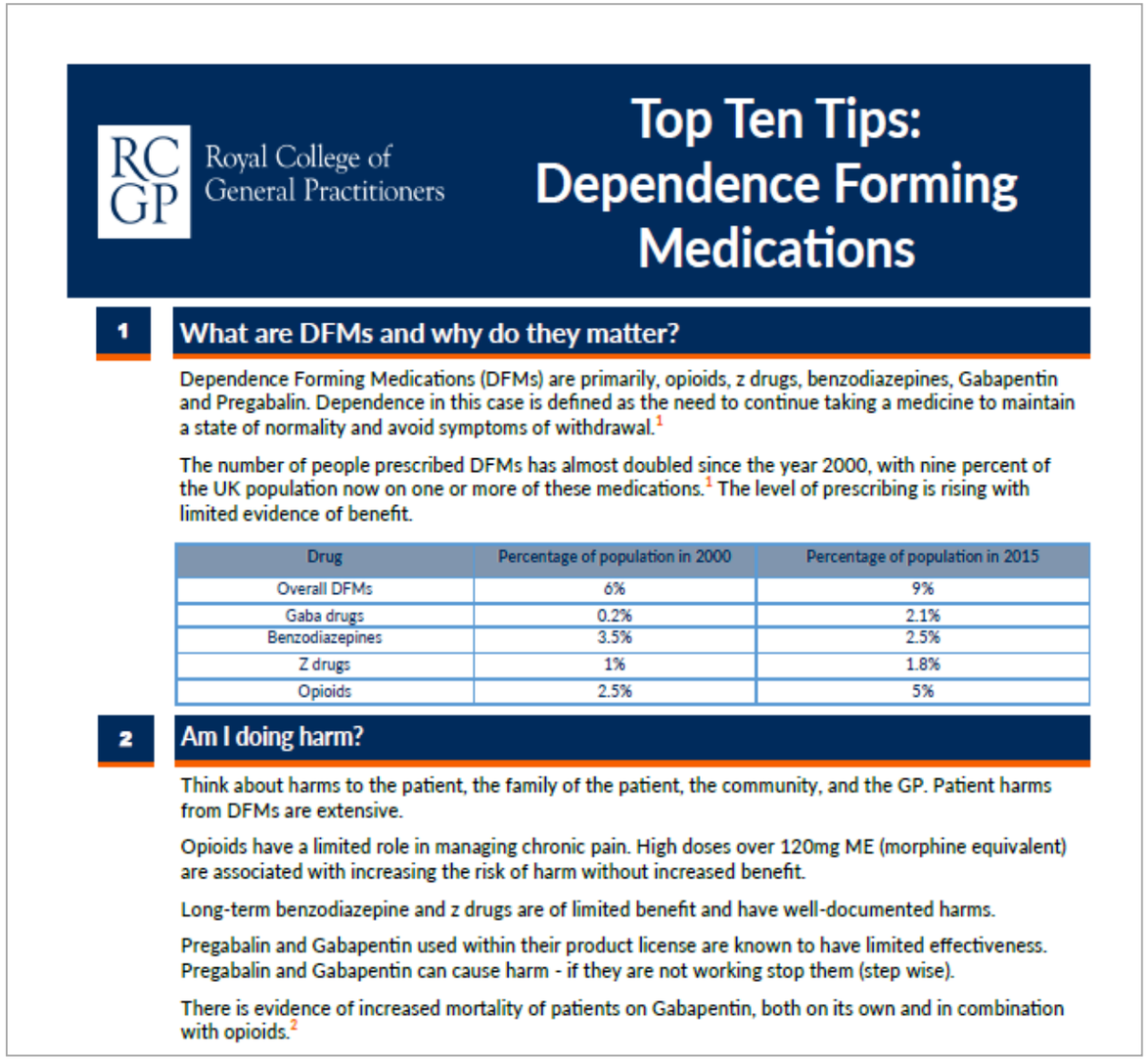
‘The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day but there is no increased benefit: **tapering or stopping high dose opioids needs careful planning and collaboration**’

https://fpm.ac.uk/opioids-aware

Resources

- Swindon Pain Champion network - collaboration between CCG & local Pain Service and GP practices - Pain Pack (links to multiple key resources), shared cases, collaborative, education/shared learning
- PrescQIPP Bulletin and Resources DFM https://www.prescqipp.info/our-resources/bulletins/bulletin-256-dependence-forming-medications/ + Various e-learning modules
- RCPGP Top 10 Tips https://www.prescqipp.info/community-resources/innovation-and-best-practice/highly-commended-gp-and-practice-clinical-pharmacist-opiate-reduction-clinic-project-2018/
- North Devon Patient Information Videos https://www.northdevonhealth.nhs.uk/services/persistent-pain-team/pain-patient-information-videos/
- Chronic Pain in Cornwall https://www.eclipsesolutions.org/Cornwall/info.aspx?bnfotherid=7
- bswccg.prescribing@nhs.net email us for support, data, signposting

RCGP Top Ten Tips: DFM



Royal College of General Practitioners

Top Ten Tips: Dependence Forming Medications

1 What are DFMs and why do they matter?

Dependence Forming Medications (DFMs) are primarily, opioids, z drugs, benzodiazepines, Gabapentin and Pregabalin. Dependence in this case is defined as the need to continue taking a medicine to maintain a state of normality and avoid symptoms of withdrawal.[1]

The number of people prescribed DFMs has almost doubled since the year 2000, with nine percent of the UK population now on one or more of these medications.[1] The level of prescribing is rising with limited evidence of benefit.

Drug	Percentage of population in 2000	Percentage of population in 2015
Overall DFMs	6%	9%
Gaba drugs	0.2%	2.1%
Benzodiazepines	3.5%	2.5%
Z drugs	1%	1.8%
Opioids	2.5%	5%

2 Am I doing harm?

Think about harms to the patient, the family of the patient, the community, and the GP. Patient harms from DFMs are extensive.

Opioids have a limited role in managing chronic pain. High doses over 120mg ME (morphine equivalent) are associated with increasing the risk of harm without increased benefit.

Long-term benzodiazepine and z drugs are of limited benefit and have well-documented harms.

Pregabalin and Gabapentin used within their product license are known to have limited effectiveness. Pregabalin and Gabapentin can cause harm - if they are not working stop them (step wise).

There is evidence of increased mortality of patients on Gabapentin, both on its own and in combination with opioids.[2]

- **Excellent concise 2 page summary**
- Clear agreement on review/follow up, aims of treatment
- Review often, don't add to repeat, record a clear indication, note total morphine daily equivalent
- Be aware and recognise drug seeking behaviours and emerging dependence and addiction, overuse, misuse, running out, early prescriptions, medication from other sources (e.g. out of hours) https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/dependence-forming-medications.aspx

Anxiolytics/Hypnotics and Z – Drugs

- NICE CKS Benzodiazepine-z-drug withdrawal https://cks.nice.org.uk/topics/benzodiazepine-z-drug-withdrawal/
- Deprescribing.org Benzodiazepine&Z-Drug Deprescribing Algorithm https://deprescribing.org/wp-content/uploads/2019/02/BZRA-deprescribing-algorithms-2019-English.pdf?UNLID=595082769201952216101 1
- NICE CKS Insomnia https://cks.nice.org.uk/topics/insomnia/
- PrescQIPP Bulletin and Resources DFM https://www.prescqipp.info/our-resources/bulletins/bulletin-256-dependence-forming-medications/
- PrescQIPP Examples of initiatives in other areas https://www.prescqipp.info/community-resources/innovation-and-best-practice/benzo-reduction-programme-2016/

Anxiolytics/Hypnotics and Z – Drugs

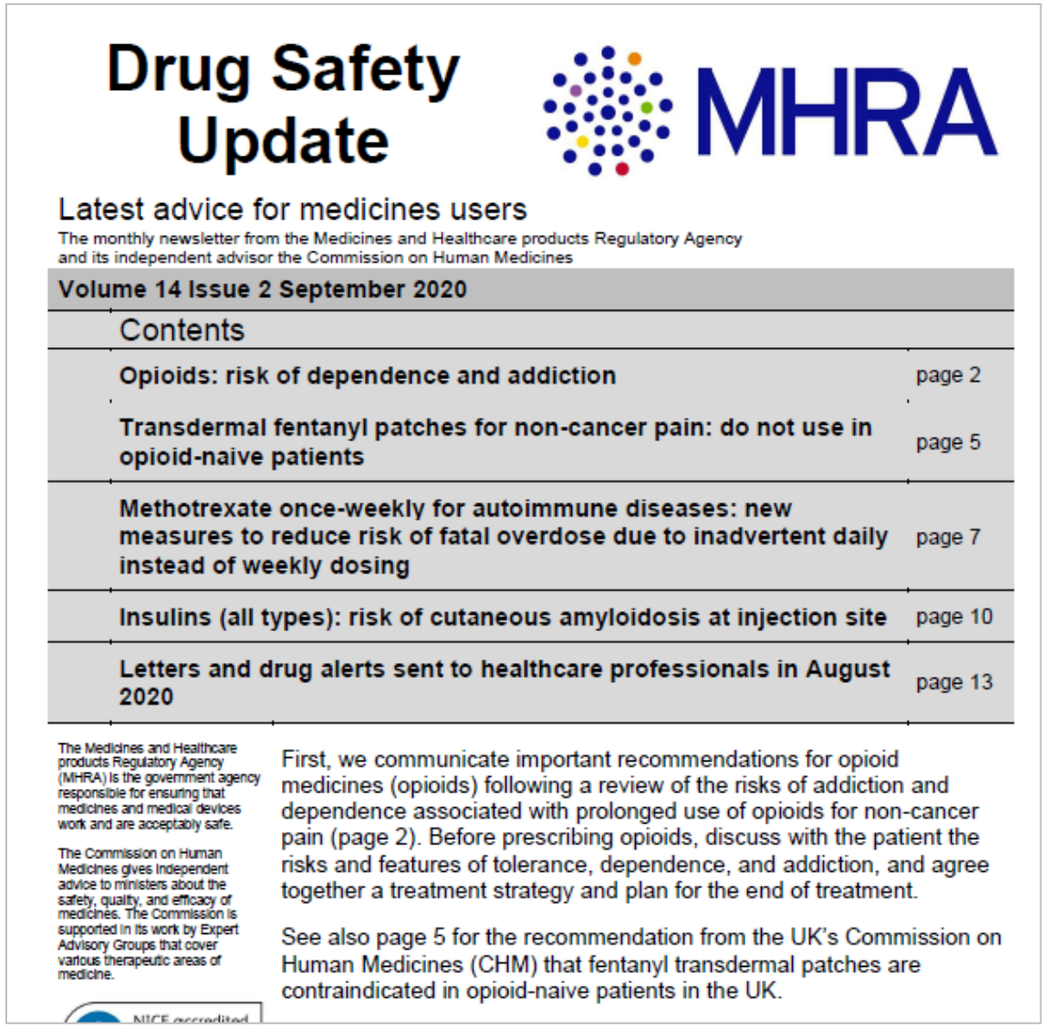
- A brief intervention in the form of either a letter or a single consultation by GPs, for long-term users of BZD, is an effective and efficient strategy to decrease or stop their medication, without causing adverse consequences

  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3162180/

- Patient UK: Insomnia, information for Medical Professionals https://patient.info/doctor/insomnia Outlines risks particularly in elderly with issues with such as memory impairment, (sometimes confused with onset of dementia), falls etc. 30% will respond to sleep hygiene advice although evidence limited. Digital CBT, apps such as mindfulness, calm and headspace

- NHS, sleep hygiene advice for patients https://www.nhs.uk/live-well/sleep-and-tiredness/how-to-get-to-sleep/

Opioids: MHRA Drug Safety Update Sept 2020



Drug Safety Update

MHRA

Latest advice for medicines users

The monthly newsletter from the Medicines and Healthcare products Regulatory Agency and its independent advisor the Commission on Human Medicines

Volume 14 Issue 2 September 2020

Contents

The Medicines and Healthcare products Regulatory Agency (MHRA) is the government agency responsible for ensuring that medicines and medical devices work and are acceptably safe.

The Commission on Human Medicines gives independent advice to ministers about the safety, quality, and efficacy of medicines. The Commission is supported in its work by Expert Advisory Groups that cover various therapeutic areas of medicine.

First, we communicate important recommendations for opioid medicines (opioids) following a review of the risks of addiction and dependence associated with prolonged use of opioids for non-cancer pain (page 2). Before prescribing opioids, discuss with the patient the risks and features of tolerance, dependence, and addiction, and agree together a treatment strategy and plan for the end of treatment.

See also page 5 for the recommendation from the UK's Commission on Human Medicines (CHM) that fentanyl transdermal patches are contraindicated in opioid-naive patients in the UK.

- Commission on Human Medicines (CHM) - Opioids Expert Working Group:
- New measures to protect patients
- Patient information leaflet (PIL) explaining risks of tolerance, addiction and overdose (including accidental overdose)
- Packaging opioid medicines should contain wording, 'Contains an opioid' and 'Can cause addiction'
- Product information should details risks of tolerance, dependence and addiction

https://www.gov.uk/drug-safety-update/opioids-risk-of-dependence-and-addiction

Opioids: MHRA Drug Safety Update Sept 2020

Advice for healthcare professionals:

- opioid medicines (opioids) provide relief from serious short-term pain; however long-term use in non-cancer pain (longer than 3 months) carries an increased risk of dependence and addiction
- discuss with patients that prolonged use of opioids may lead to drug dependence and addiction, even at therapeutic doses – warnings have been added to the labels (packaging) of UK opioid medicines to support patient awareness
- before starting treatment with opioids, agree with the patient a treatment strategy and plan for end of treatment
- explain the risks of tolerance and potentially fatal unintentional overdose, and counsel patients and caregivers on signs and symptoms of opioid overdose to be aware of (see opioids safety information leaflet)
- provide regular monitoring and support especially to individuals at increased risk, such as those with current or past history of substance use disorder (including alcohol misuse) or mental health disorder
- at the end of treatment, taper dosage slowly to reduce the risk of withdrawal effects associated with sudden cessation of opioids; tapering from a high dose may take weeks or months
- consider the possibility of hyperalgesia if a patient on long-term opioid therapy presents with increased sensitivity to pain
- consult the latest advice and warnings for opioids during pregnancy in the product information and in clinical resources
- report suspected dependence or addiction to any medicine, including to an opioid, via the Yellow Card scheme

- Increased risk of addiction >3 months duration
- Discuss addictive potential with patient
- Treatment strategy and plan for end of treatment
- Warn potential for tolerance and overdose including unintentional
- Regular follow up monitoring/support
- Taper dose to reduce risk withdrawal symptoms

https://www.gov.uk/drug-safety-update/opioids-risk-of-dependence-and-addiction