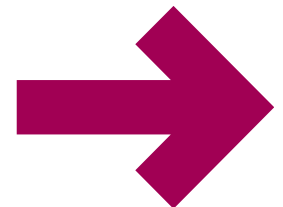


New NICE Guidance on Primary Care Prescribing

Sue Mulvenna
Head of Pharmacy and
CD Accountable Officer
South Region SW
29th November 2016

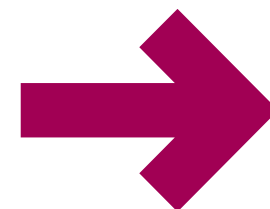
NICE Guidance

- The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
- Producing evidence-based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
- Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.



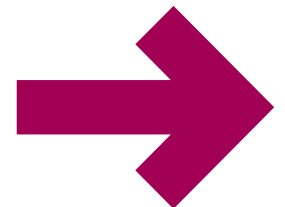
NICE Primary Care – new advice on prescribing

- Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use NG15 Published August 2015
- Multimorbidity: clinical assessment and management NG56 Published September 2016
- Controlled drugs: safe use and management NG46 Published April 2016
- Dementia: CG42 updated September 2016
- Palliative care for adults: strong opioids for pain relief CG140 updated: August 2016



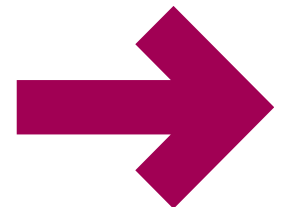
Antimicrobial stewardship NG15

- An organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness
- Antimicrobial resistance (AMR) threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi.
- Without effective antibiotics, the success of major surgery and cancer chemotherapy would be compromised.



Antimicrobial resistance – global areas of concern

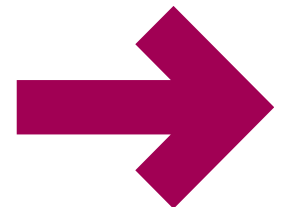
- 480,000 people develop multi-drug resistant TB each year only half of these were successfully treated in 2014
- Malaria - along the Cambodia-Thailand border, *P. falciparum* has become resistant to almost all available antimalarial medicines
- HIV – in some countries 15% have drug-resistant HIV, with up to 40% among people re-starting treatment being resistant to antiretroviral therapy. 3rd line regimens are 18x more expensive than 1st line meds



The WHO global action plan on AMR

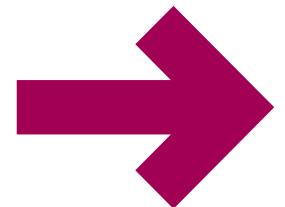
Has 5 strategic objectives:

- To improve awareness and understanding of antimicrobial resistance
- To strengthen surveillance and research
- To reduce the incidence of infection
- To optimize the use of antimicrobial medicines
- To ensure sustainable investment in countering antimicrobial resistance



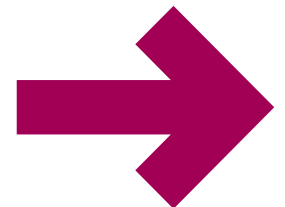
Antimicrobial stewardship NG15 – recommendations for prescribers

- Follow local or national antimicrobial prescribing **guidelines**
- For recurrent or persistent infections, **take microbiological samples** when prescribing and review the prescription when the results are available
- Take **time to discuss alternative options** with the patient and/or their family or carers
- Do not issue an immediate prescription for an antimicrobial to a patient who is likely to have a **self-limiting** condition



Support for GPs to avoid AMR

- BNSSG antimicrobial prescribing guideline
- Resources to give patients/parents
- Support with risk assessment for individual patients eg small children
- Messages to patients about preventing infections – for waiting room TV?
- Deferred prescriptions?
- Point of care testing?



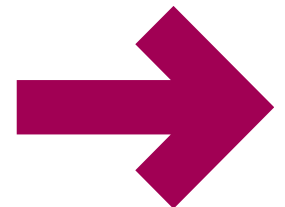
Supporting material

BNSSG antimicrobial prescribing guidelines

<http://www.bnssgformulary.nhs.uk/includes/documents/Antimicrobial%20Rx%20Guidelines%20for%20BNSSG%202015%200version%203%20final..pdf>

Patient leaflet resources

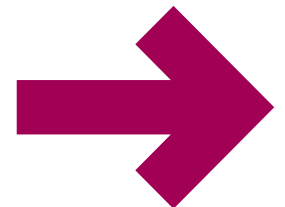
- <http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/documents/target/caring-for-children-with-cough-leaflet-print-ready.pdf>
- <http://child-cough.bristol.ac.uk/>
- <http://www.rcgp.org.uk/TARGETantibiotics>



The Target Study

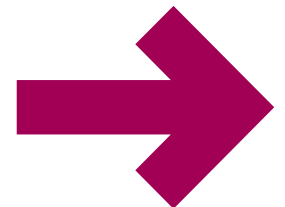
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3765099/>

- a new algorithm to support antibiotic prescribing when treating children with RTIs and cough
- can identify which children more likely to go on to need hospital care for their RTI – helping to avoid the use of 'just-in-case' antibiotics
- the algorithm identifies risk as 'very low', 'normal' and 'high'
- Just one feature indicates very low risk of requiring hospitalisation for their RTI in the following 30 days - at around 1:300



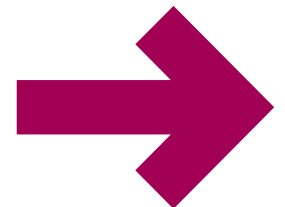
Target algorithm - STARWAVE

- Short illness (≤ 3 days)
- Temperature (parent reported severe in previous 24 hours or $\geq 37.8^\circ$ on examination)
- Age (< 2 years)
- Recession (intercostal or subcostal)
- Wheeze (on listening to chest with stethoscope)
- Asthma
- Vomiting (parent reported moderate / severe in previous 24 hours)



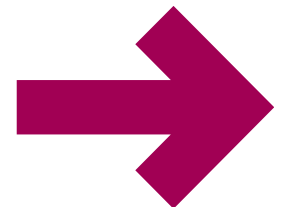
AMR discussion points

- Do you use the BNSSG antimicrobial prescribing guidelines?
- Do you think the STARWAVE algorithm will be helpful?
- Do you use deferred prescriptions, and if so do you think they work?
- Can anyone else in the practice help with patient/parent discussions, eg new parent meetings?



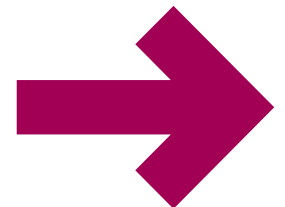
Multimorbidity: clinical assessment and management NG56

- Covers optimising care for adults with multimorbidity by reducing treatment burden (polypharmacy and multiple appointments) and unplanned care
- Aims to improve quality of life by promoting shared decisions based on what is important to each person in terms of treatments, health priorities, lifestyle and goals



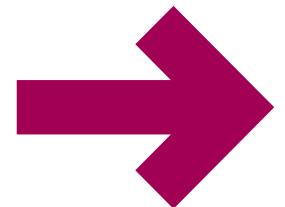
Which patients?

- Multimorbidity is common, becomes more common as people age, and is more common in people from less affluent areas
- In older people, multimorbidity is linked to higher rates of physical health conditions
- In younger and poorer people, multimorbidity is often due to a combination of physical and mental health conditions (notably depression)



Multimorbidity problems

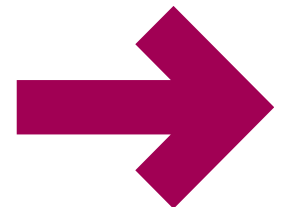
- Reduced quality of life
- Higher mortality
- Polypharmacy and high treatment burden
- Higher rates of adverse drug events
- Much greater health services use (including unplanned or emergency care)
- Burdensome treatment regimens
- Uncoordinated and fragmented care



Multimorbidity definition

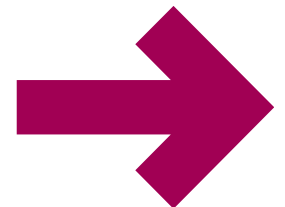
The presence of 2 or more long-term health conditions, which can include:

- defined physical and mental health conditions such as diabetes or schizophrenia
- ongoing conditions such as learning disability
- symptom complexes such as frailty or chronic pain
- sensory impairment such as sight or hearing loss
- alcohol and substance misuse



Multimorbidity and prescribing

- Take account of multimorbidity for adults of any age who are prescribed 15 or more regular medicines
- Consider a tailored approach to care for adults of any age with multimorbidity who are prescribed 10 to 14 regular medicines
- Also those prescribed fewer than 10 regular medicines, but are at particular risk of adverse events



Top 10 medicines to put you in hospital

1. NSAIDs including aspirin 29.6%
2. Diuretics 27.3%
3. Warfarin 10.5%
4. ACEI/A2RAS 7.7%
5. Antidepressants including lithium 7.1%
6. Betablockers 6.8%
7. Opiates 6.0%
8. Digoxin 2.9%
9. Prednisolone 2.5%
10. Clopidogrel 2.4%

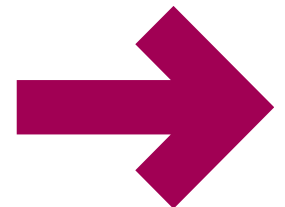
<http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/StopstartToolkit2011.pdf>



Individualised management plan

To be agreed with the person, including

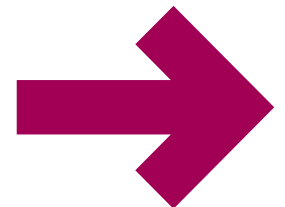
- goals and plans for future care (including advance care planning)
- who is responsible for coordination of care
- how the individualised management plan and the responsibility for coordination of care is communicated to all professionals and services involved
- timing of follow-up and how to access urgent care



Ways to improve quality of life

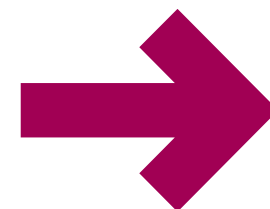
Reducing treatment burden and optimising care by identifying:

- ways of maximising benefit from existing treatments
- treatments that could be stopped because of limited benefit
- treatments and follow-up arrangements with a high burden
- medicines with a higher risk of adverse events (for example, falls, gastrointestinal bleeding, acute kidney injury)
- non-pharmacological treatments as possible alternatives to some medicines



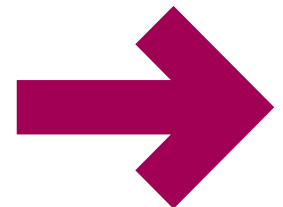
High risk situations for adverse drug reactions

- 25-50% of over 85s are frail – ie have reduced functional reserve, so high risk of rapid decline with any stressful situation eg a fall, loss of partner, moving home
- Care Homes – 70% of residents exposed to mistakes in medication every day (CHUMs review)
- Transfer of care between home, hospital and care home



Recommendations: how to assess frailty

- When assessing frailty in primary and community care settings, consider using 1 of the following :
 - an informal assessment of gait speed
 - self-reported health status
 - that is, ‘how would you rate your health status on a scale from 0 to 10?’, with scores of 6 or less indicating frailty
 - a formal assessment of gait speed, with more than 5 seconds to walk 4 metres indicating frailty
 - the PRISMA-7 questionnaire, with scores of 3 and above indicating frailty

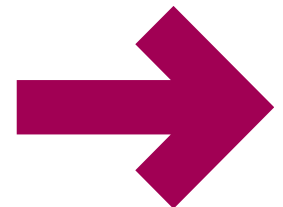


Prisma 7 Questions

- Are you more than 85 years?
- Male?
- In general do you have any health problems that require you to limit your activities?
- Do you need someone to help you on a regular basis?
- In general do you have any health problems that require you to stay at home?
- In case of need can you count on someone close to you?
- Do you regularly use a stick, walker or wheelchair to get about?

3 or more suggests review

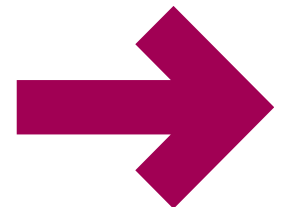
http://www.bgs.org.uk/campaigns/fff/fff_short.pdf



Medication reviews

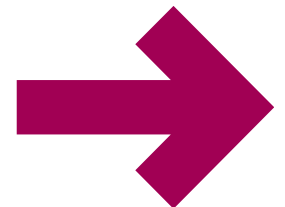
When reviewing medicines:

- use tools like STOPP/START to identify safety issues
- avoid high risk combinations such as:
 - NSAID plus ACE inhibitor or diuretic,
 - NSAID plus tricyclic antidepressant or glitazone
 - Warfarin plus antiplatelet or NSAID or some antibiotics
- be alert to the possibility of depression, anxiety or chronic pain - is this being diagnosed and optimally managed?



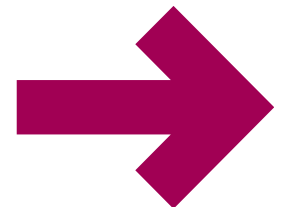
Multimorbidity discussion points

- Do you risk assess patients for multimorbidity?
- How do you assess frailty in your patients?
- How do you manage care plan discussions with housebound or care home patients?
- How are medication reviews done in high risk patients?
- Do you have a practice pharmacist, if so do they help with managing these patients?



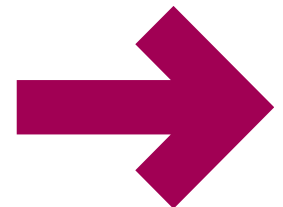
Controlled drugs: safe use and management NG46

- Brings together controlled drugs legislation, policy, good practice advice and published evidence
- Aims to support robust and effective processes without interfering with appropriate use of CDs and good clinical care



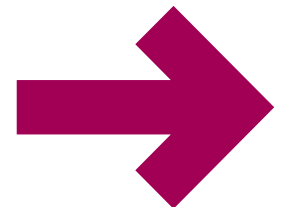
Controlled drugs legislation

- **The Misuse of Drugs Act 1971** and Regulations divide CDs into 5 Schedules, related to risk of misuse and controls required. The Regulations also establish controls around prescribing, administering, safe custody, dispensing, record keeping, and destruction or disposal
- **The Controlled Drugs (Supervision of Management & Use) Regulations 2013** set out the core duties and functions of CDAOs
- **The Medicines Act 1968** sets out the requirements of a valid prescription and permits some professional groups to supply or administer CDs



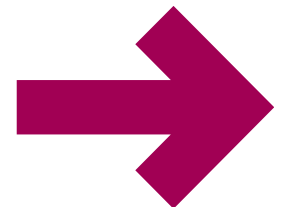
Misuse of Drugs - CD Schedules

- Schedule 1 – no generally accepted therapeutic use, eg cannabis, mescaline – need a license to possess
- Schedule 2 - subject to the full controlled drug requirements; e.g. diamorphine, pethidine, cocaine, methadone, methylphenidate, fentanyl, oxycodone
- Schedule 3 – eg temazepam, buprenorphine, midazolam tramadol
- Schedule 4 - Part 1 (CD Benzodiazepines) and Part 2 (CD Anabolic Steroids)
- Schedule 5 – eg dihydrocodeine, codeine, morphine sulfate 10mg/5ml



Considerations for GP practices

- Management of CD stock, including safe storage, record keeping and witnessed destruction of out of date CD stock (as in GP CD SOP)
- Reporting of CD related incidents to the NHS England CDAO at england.southwestcontrolleddrugs@nhs.net
- Adhering to best practice requirements for CD prescribing
- Having a practice policy for prescription form security



Controlled Drugs guidance

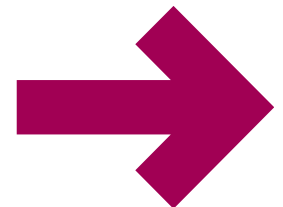
- GP CD Standard Operating Procedure

<http://www.bnssgformulary.nhs.uk/includes/documents/CD%20SOP%202015%20v7.pdf>

- Checklist for prescription form security: request from england.southwestcontrolleddrugs@nhs.net

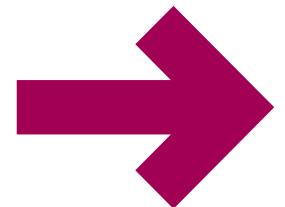
- Controlled Drugs (Supervision of management and use) Regulations 2013 – information about the regulations

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214915/15-02-2013-controlled-drugs-regulation-information.pdf



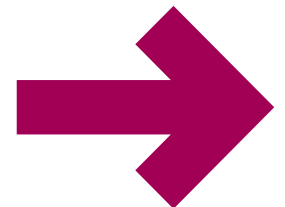
Key CD priorities for GP practices

- Ensuring all prescribers initiating a CD comply with **recommendations** re prescribing, monitoring, reviewing, and providing information and advice
- Ensuring all patients with ongoing prescriptions for CDs have regular documented **reviews**
- Reviewing existing systems, **policies** and SOPs related to CDs
- Appointing a nominated **person to lead** on the safe use and management of CDs, including reporting of concerns



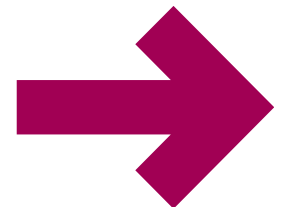
Before prescribing controlled drugs, consider:

- The benefits of controlled drug treatment
- The risks of prescribing, including dependency, overdose and diversion
- All prescribed and non-prescribed medicines the person is taking (particularly any centrally acting agents)
- Whether the person may be opioid naive



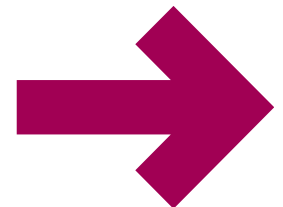
Prescribing controlled drugs

- **Document clearly** the indication and regimen for the controlled drug in the person's care record
- **Discuss** with the person the arrangements for reviewing and monitoring treatment
- Include dosage instructions on the prescription (with the **maximum daily amount** or frequency of doses) so that this can be included on the label when dispensed
- Prescribe enough of a controlled drug to meet the person's clinical needs for **no more than 30 days**. If, under exceptional circumstances, a larger quantity is prescribed, the reasons for this should be documented in the person's care record.



Information for patients

- What it has been prescribed for, and how long it will take to work
- How long the person is expected to use the drug
- How to use controlled drugs when sustained-release and immediate-release formulations are prescribed together
- How it may affect the person's ability to drive
- That it is to be used only by the person it is prescribed for
- Inform people who are starting controlled drugs that they or their representative may need to show identification when they collect the controlled drugs.
- Advise people how to safely dispose of unwanted controlled drugs at a community pharmacy

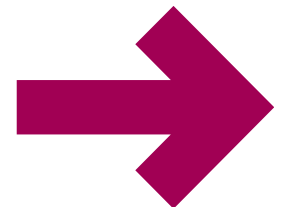


CDs and driving - advice for patients

MHRA advice

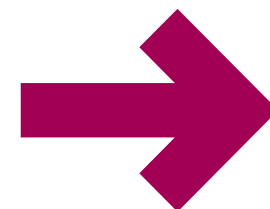
<https://www.gov.uk/drug-safety-update/drugs-and-driving-blood-concentration-limits-set-for-certain-drugs>

- If the police are satisfied that a driver is taking the relevant medicine on the advice of a healthcare professional the police will not prosecute them for this offence
- However, it remains the responsibility of all drivers, including patients, to consider whether they believe their driving is, or might be, impaired on any given occasion, for example if they feel sleepy
- If their driving was impaired by their medication, then they could be prosecuted



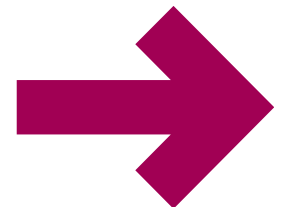
Opioids aware – driving advice

- Drivers who tested positive for **morphine** were 8 -32 times more likely to be injured or responsible for a road traffic collision compared with those who did not have a positive test result.
- A patient on high dose morphine (around 200mg/24hours) could be as impaired as someone with blood alcohol around the level above which it is illegal to drive.
- A patient also drinking or taking other sedative drugs could be impaired at a lower morphine dose.
- Prescribers of opioid medicines must be aware of the likely impairing effects of the drugs and must advise patients accordingly
- <https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware/best-professional-practice/opioids-and-driving>



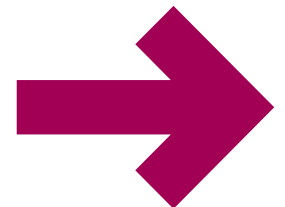
Opiates for chronic pain

- Community prescribing of opioids has more than doubled in last 10 years
- 10% of patients on long term opioids are prescribed potentially hazardous doses
- Chronic opioid use is associated with reduced quality of life and increased mortality
- 50 – 80% of patients experience side effects
- 8 – 12% of long term opioid users meet criteria for addiction



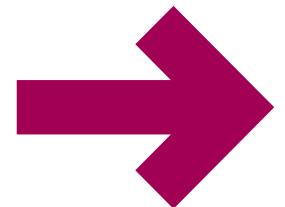
Five main points

- Opioids are good analgesics for acute and EOLC but not usually helpful for long term pain
- A few patients may benefit from intermittent low dose opioids long term
- The risk of harm increases above a dose greater than 120mg morphine daily, with no increased benefit
- If a patient on opioids is still in pain, they should be discontinued – even if no other treatment is available
- Chronic pain is very complex – once patients are on high dose of opioids and still have disabling symptoms, then a specialist assessment will be needed



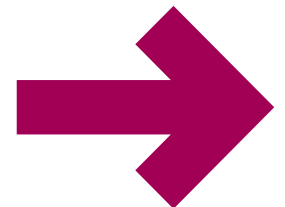
CDs – points for discussion

- Do you have a CD policy in your practice?
- Do you know who to tell if there is a CD related incident?
- Do you advise patients on high dose morphine about driving?
- How do you manage your high dose opioid patients with chronic pain?



Dementia: supporting people with dementia and their carers in health and social care CG42 Sept 16 update

- Also TA217 Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease
- Clinical Guideline covers patient centred care, capacity, consent, non-discrimination, support for carers, managing challenging behaviour, diagnosis, and treatment

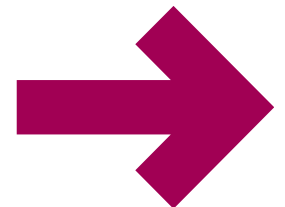


Updated guidance on treatment

Non-specialists can now prescribe donepezil, galantamine, rivastigmine and memantine, as long as they have taken advice from a clinician who has the necessary knowledge and skills

This includes:

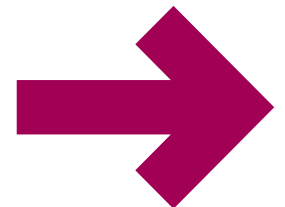
- secondary care medical specialists such as psychiatrists, geriatricians and neurologists
- other healthcare professionals such as GPs, nurse consultants and advanced nurse practitioners with specialist expertise in diagnosing and treating Alzheimer's disease



Behaviour that challenges

People with dementia who are significantly distressed or who develop behaviour that challenges should have the following assessed ,with carer and care worker input:

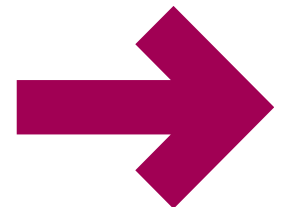
- the person's physical health
- depression
- possible undetected pain or discomfort
- side effects of medication
- individual biography, including religious beliefs and spiritual and cultural identity
- psychosocial factors
- physical environmental factors



Commonly prescribed medicines with high anticholinergic activity

These can worsen symptoms of dementia

- Medicines for urinary frequency eg tolterodine, oxybutynin
- Tricyclic antidepressants eg amitriptyline
- Antihistamines eg chlorpheniramine, diphenhydramine (Nytol)
- Antipsychotics eg quetiapine, olanzapine



Dementia diagnosis and management -A brief pragmatic resource for general practitioners

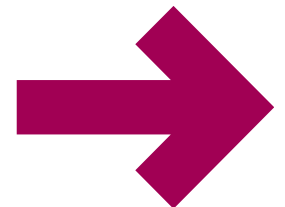
<https://www.england.nhs.uk/wp-content/uploads/2015/01/dementia-diag-mng-ab-pt.pdf>

Alistair Burns, National Clinical Director for Dementia, NHS England

<https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf>

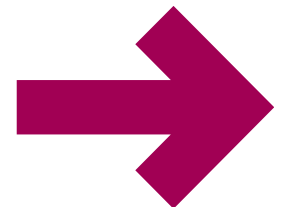
Dr Elizabeth Barrett, Shires Health Care – Hardwick CCG
Professor Alistair Burns, NHS England

July 2014 – a much fuller guidance document



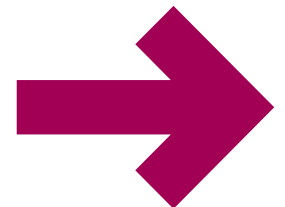
After reading and reflecting on this resource pack GPs should be able to

- Describe the key features of dementia and explain which patients particularly merit referral to the specialist service;
- Describe the role of cognitive testing in the diagnosis and management of dementia and produce a plan for their own practice which incorporates appropriate tools;
- Explain how and when anti-dementia treatments in primary care are safe to be introduced
- Create a strategy for themselves and their practice to improve the detection and management of dementia



Dementia – points for discussion

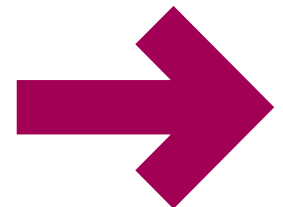
- How confident are you to diagnose dementia and initiate treatment?
- Do you think there is a place for antipsychotics in the treatment of behavioural problems in dementia?
- Do you consider the possible role of anticholinergic drugs when patients first have dementia symptoms?



Palliative care adults strong opioids

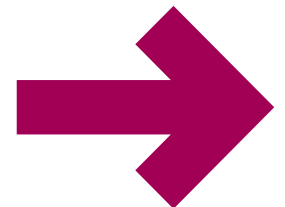
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- Up to two-thirds of people with cancer experience pain that needs a strong opioid (similar or higher in many other advanced and progressive conditions)
- Evidence suggests that pain which results from advanced disease, especially cancer, remains under-treated



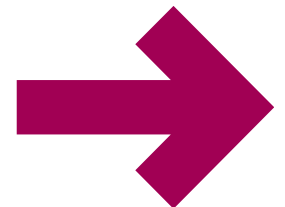
Prescribing guidance

- Sustained-release morphine first-line maintenance treatment, with immediate-release morphine for the first-line rescue medication for breakthrough pain
- For patients with no renal or hepatic comorbidities, starting dose of 20–30 mg of oral morphine (eg 10–15 mg oral sustained-release morphine twice daily), plus 5 mg oral immediate-release morphine for rescue doses during the titration phase
- Adjust the dose until a good balance exists between acceptable pain control and side effects



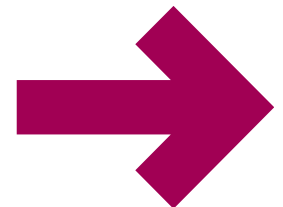
Side effects

- Constipation - prescribe laxative treatment (to be taken regularly at an effective dose) for all patients initiating strong opioids
- Nausea – may settle, but if persists, prescribe and optimise anti-emetic treatment before considering switching strong opioids
- Drowsiness - is often transient, but warn patients that impaired concentration may affect their ability to drive and undertake other manual tasks
- Other CNS side effects – reduce dose if pain controlled, or switch opioid if not



Cautions

- Use a recognised opioid dose conversion guide when prescribing, reviewing or changing opioid prescriptions to ensure that the total opioid load is considered.
- Seek specialist advice before prescribing strong opioids for patients with moderate to severe renal or hepatic impairment
- Seek specialist advice if needed for transfer to patches or subcut injections



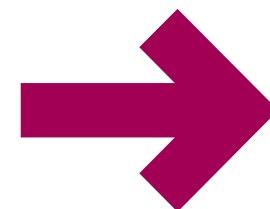
Supporting information for GPs

BNSSG End of life care prescribing / just in case guidance

- <http://www.bnssgformulary.nhs.uk/includes/documents/Just%20in%20case%20guidance%20notes%20BNSSG%20Dec14.pdf>
- <http://www.bnssgformulary.nhs.uk/includes/documents/Just%20in%20case%20policy%20BNSSG%20Dec14.pdf>

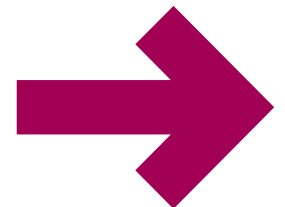
Pharmacies stocking injectable opioids

- <http://www.bnssgformulary.nhs.uk/includes/documents/NHS%20England%202015-16%20Community%20Pharmacy%20Specialist%20Meds%20Service%20letter%20and%20info.pdf>



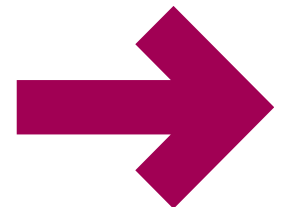
Palliative care – points for discussion

- Do you think palliative care patients are reluctant to take opioids?
- Do you know where to get opioid injections on prescription when needed urgently?
- Have you had any problems with the national diamorphine shortages?



Some useful links

- BNSSG formulary prescribing guidelines
- <http://www.bnssgformulary.nhs.uk/Local-Guidelines/>
- Numbers needed to treat – to aid prescribing decisions
- <http://www.thennt.com/home-nnt/>
- <https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware> opioids aware website and materials
- <https://www.nice.org.uk/>



Contact me

Controlled Drugs

for CD advice and guidance or to report a CD incident

Email me at

ENGLAND.southwestcontrolleddrugs@nhs.net

Or phone 0113 824 8129 and leave a message with
Vicky Bawn

Medicines optimisation

If interested in the topics covered and want more
information, email me at sue.mulvenna@nhs.net

