National Patient Safety
Improvement Programmes

NHS

Medicines

UCLPartners Opioids Working Group

Thursday 26th January 2023

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Delivered by:

UCLPartners
Patient Safety Collaborative

TheAHSNNetwork

Led by:

NHS England
NHS Improvement

UCLPartners Team

Aiysha Saleemi

Pharmacist Advisor
MedSIP Workstream Lead

Mandeep Butt

Medicines
Optimisation Lead

Jessica Catone

Project Manager
Polypharmacy

Valentina Karas

Director of Implementation,
Patient Safety

UCLPartners Core Working Group

Name	Job Title/Organisation
Aiysha Saleemi	MedSIP Workstream Lead, **UCLPartners**
Mandeep Butt	MedSIP Clinical Lead, **UCLPartners**
Amandeep Setra	Medicines Safety Officer and Lead Pain Management Pharmacist, **UCLH**
Anh Vu	Joint Formulary Pharmacist, **NEL ICB** + Lead Pain Management Pharmacist, **Homerton University Hospital**
Eric Chu	Senior Prescribing Advisor, **NEL Integrated Care Board**
Julia Taylor	Senior Prescribing Advisor, **NEL Integrated Care Board**
Helene Simonson	BOWS manager, NMP Nurse, **Camden and Islington NHS Foundation Trust**
Sarah Wombell	Senior Clinical Nurse Specialist Pain Management, **BHR Hospital**
Bernard Cheng	Lead Surgical Pharmacist, **North Middlesex University Hospital**
Dalveer Johal	**NEL Local Pharmaceutical Committee**
EY Cheung	**Deputy Head of Medicines Management, NCL Integrated Care Board**
Kristina Petrou	**NCL Integrated Care Board**
Yogendra Parmar	**Camden and Islington Local Pharmaceutical Committee**
Marsha Alter	**Barnet, Enfield and Haringey Local Pharmaceutical Committee**
Nisha Patel	Senior Pharmacist, **Haringey GP Federation**

Recap and Plan

Recap – Last Opioids Network meeting (October 2022):

- Presentations from primary and secondary care on why there is an issue of overprescribing opioids and possible interventions to reduce this.
- Heard from 2 patients with persistent non-cancer pain on their pain journeys.
- Presentations from Benzodiazepine and Opioids Withdrawal Service in NCL and Turning Point who work in NEL.
- Breakout rooms to discuss what local initiatives have been done to reduce opioids.

Plan – todays event:

- Bring together primary care and NHS Trusts to explore how we can build better relationships and work together in tackling inappropriate opioid prescribing.

Agenda

Time	Session	Facilitator
12:00	Welcome and Introductions	Mandeep Butt, UCLP Medicines Safety Clinical Lead
12:05	Brief Introduction to Opioids National Programme	Aiysha Saleemi, UCLP Pharmacy Advisor
12:15	Primary Care Workforce Survey Results	Jessica Catone, UCLP Project Manager
12:30	Opioid Stewardship within Acute Trusts	Amandeep Setra, UCLH Medicines Safety Officer
12:45	Open discussion – Miro Board	All
13:15	Next Steps	Mandeep Butt, UCLP Medicines Safety Clinical Lead
13:30	Close	

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National Opioids Programme

Aiysha Saleemi, Pharmacist Advisor (MedSIP Workstream Lead)

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Academic Health Science Networks (AHSN)

- 15 AHSNs across the country
- 3 AHSNs in London
  - Health Innovation Network
  - Imperial College Health Partners
  - University College London Partners
- Commissioned by NHS England, NHS Improvement and the Office for Life Sciences to spread proven innovations within each AHSN's locality
- Our aim is to benefit patients, save the NHS money and create health and social care efficiencies

UCLPartners **Patient Safety Collaborative**

Overall Aim

To reduce severe avoidable medication related harm by

50% by March 2024

Primary Driver – Improve care of people living with chronic pain

Secondary Driver – Reduce harm from opioids

Deliverables

- Minimum of one ICS to implement a Whole Systems Approach
- 30,000 fewer people prescribed opioids for >3 months
- 4,500 to be stopped (high dose opioid)
- ePACT2 national (opioid dashboard) and local data
- NHS England dashboard on opioid prescribing

London Opioids Use (over 4 weeks: 31st August – 27th September 2022)

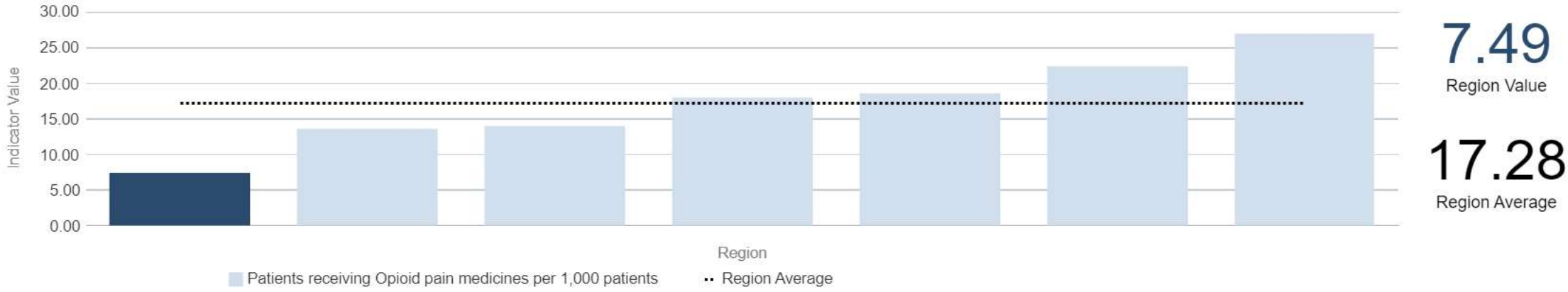
* **Comparator** OP01 - Patients receiving opioid pain medicines
* **Reporting Level** Comparison
* **Region** LONDON
* **Gender** Female Male
* **Age Band** (All Column Values)

In this comparator opioid pain medicines excludes injectables and compound analgesics such as co-codamol and co-dydramol

OP01 - Patients receiving opioid pain medicines per 1,000 patients
within the LONDON region
Period 31 August 2022 to 27 Septemb **Gender** Female,Male **Age Range** (All Column Values)

Numerator Definition Denominator Definition

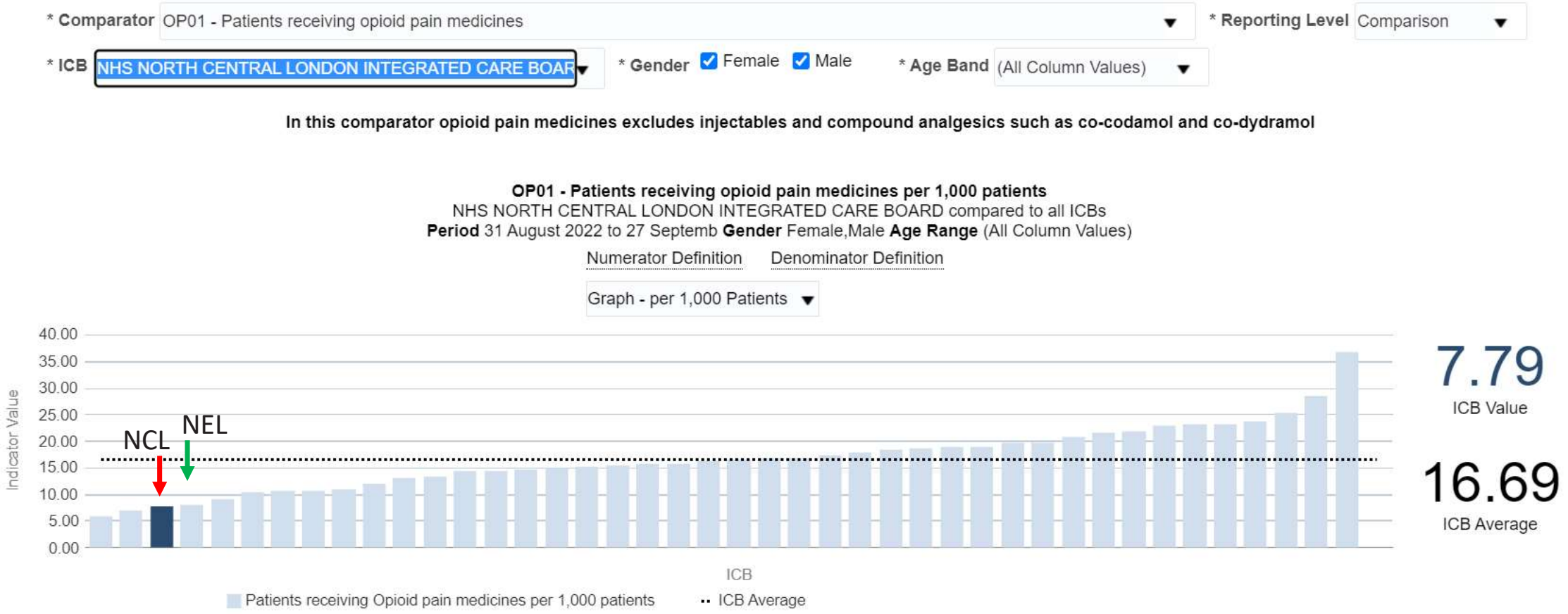
Graph - per 1,000 Patients



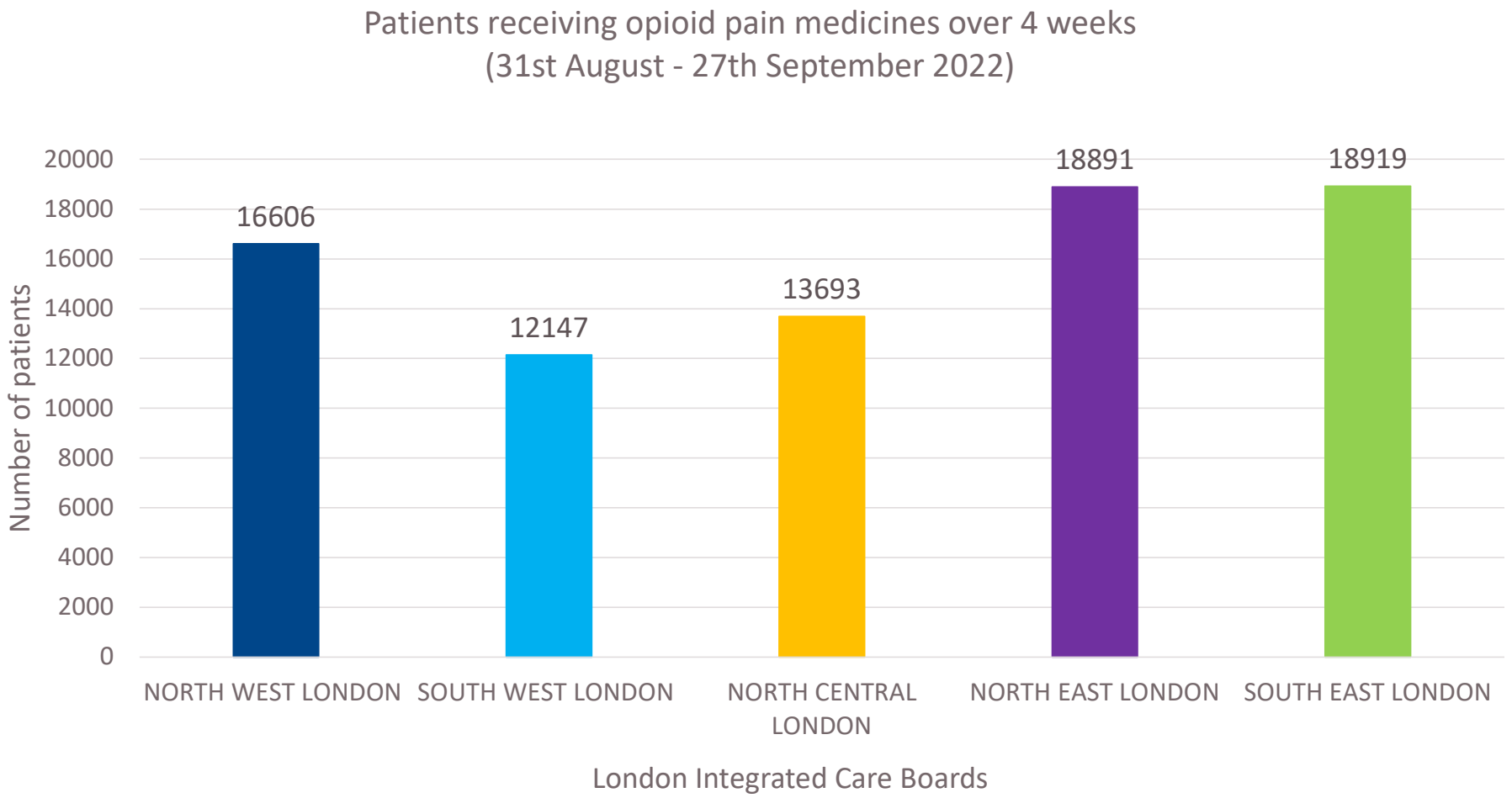
7.49
Region Value

17.28
Region Average

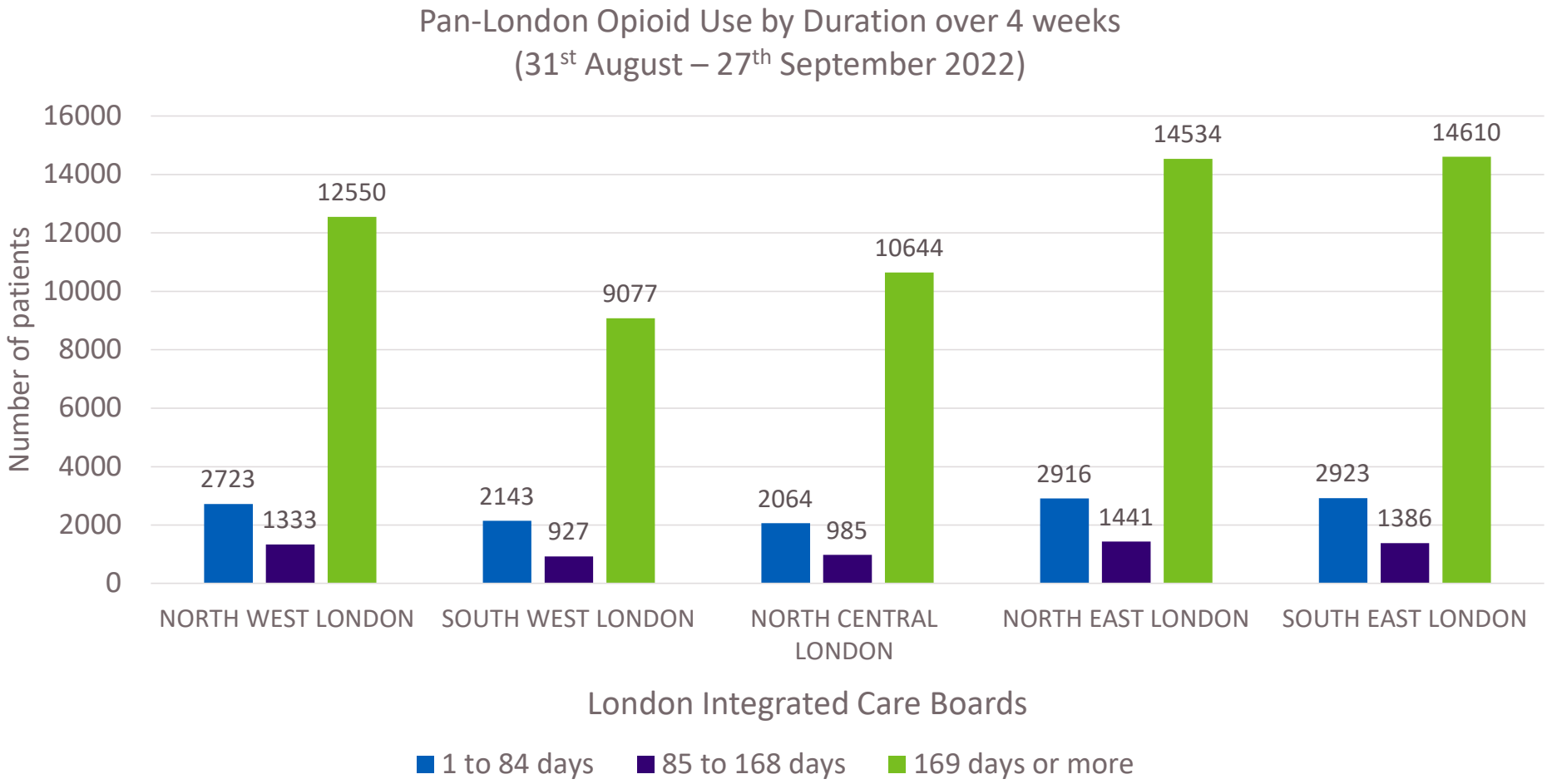
London Opioids Use (over 4 weeks: 31st August – 27th September 2022)



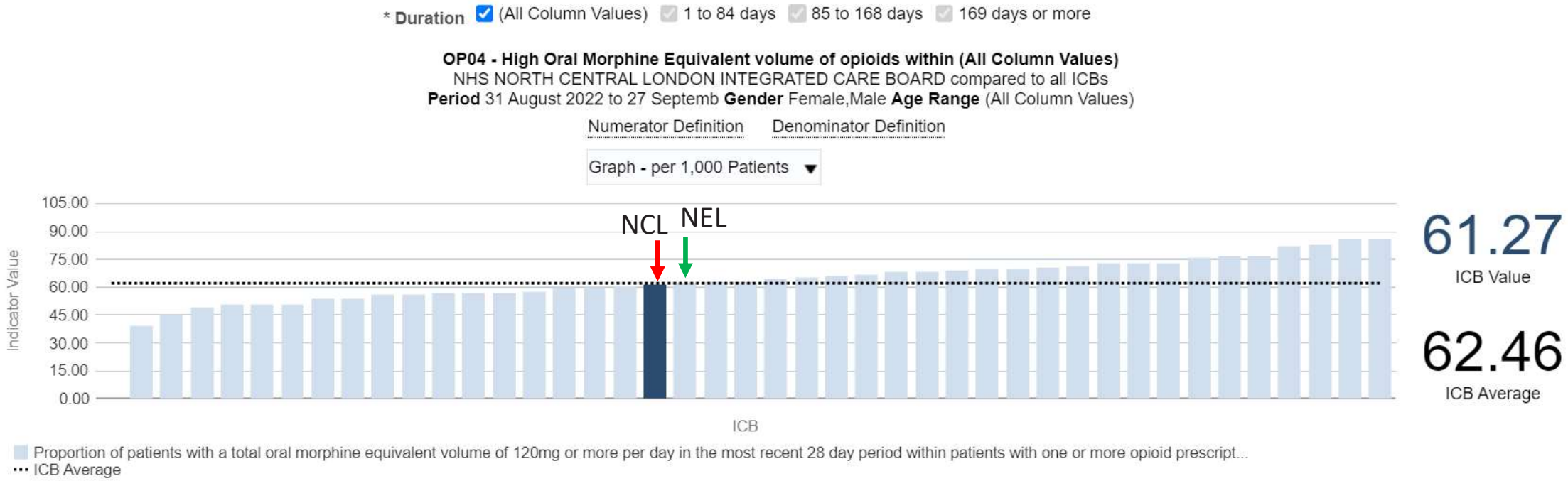
London Opioid Use



London Opioid Use



London Opioids Use (>120mg Morphine Equivalent)



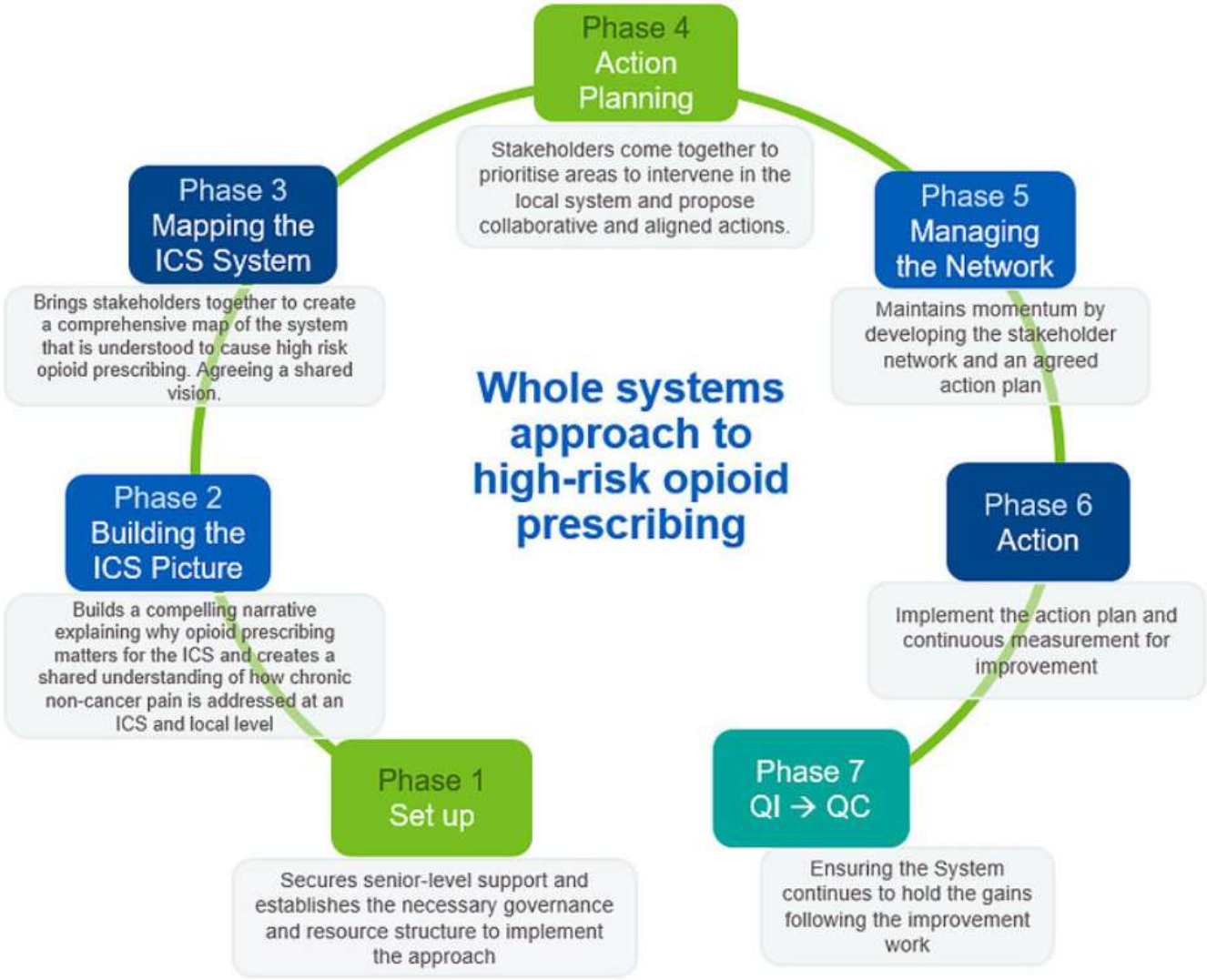
Change Package

1. How to Implement a Systems Wide Approach – 7 phases

2. Resources on NHS Futures Website – 5 themes*

PREVENT INITIATION | DE-ESCALATE | FIND CHRONIC USE | TREAT (TAPER & SUPPORT) | SUSTAIN

*For information on how to access the NHS Futures workspace for this work, email aiysha.saleemi@uclpartners.com


Phase 4
Action
Planning
Stakeholders come together to prioritise areas to intervene in the local system and propose collaborative and aligned actions.
Phase 3
Mapping the
ICS System
Brings stakeholders together to create a comprehensive map of the system that is understood to cause high risk opioid prescribing. Agreeing a shared vision.
Phase 5
Managing
the Network
Maintains momentum by developing the stakeholder network and an agreed action plan
Whole systems approach to high-risk opioid prescribing
Phase 2
Building the
ICS Picture
Builds a compelling narrative explaining why opioid prescribing matters for the ICS and creates a shared understanding of how chronic non-cancer pain is addressed at an ICS and local level
Phase 6
Action
Implement the action plan and continuous measurement for improvement
Phase 1
Set up
Secures senior-level support and establishes the necessary governance and resource structure to implement the approach
Phase 7
QI → QC
Ensuring the System continues to hold the gains following the improvement work

Timeline of National Opioids Programme

Phases description	Output	Q1			Q2			Q3			Q4		
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Phase 1 - Set up	Presented to NCL/NEL		Q1 ALS										
	First working group meeting			CWG 1									
Phase 2 - Build ICS Picture	Engaging with key stakeholders, building CWG membership				CWG 2								
Phase 3- Mapping ICS System - Workshop 1 (Opioids Network)	System mapping/draft shared vision					Q2 ALS	CWG 3;	W1					
Phase 4 - Action Planning - Workshop 2	Action plan/Driver diagram						Survey	EoI	CWG 4				
Phase 5 - Managing the network	Shared vision, agreed action plan Sustainability plans												
Phase 6 - Action	Implementation of action plan Continuous measurement								Q3 ALS		W2		
Phase 7 - QI to QC	Sustainability model											CWG 5; ALS 4	W3

Key
CWG = Core Working Group
W = Workshop (UCLP Opioids Network)
ALS = Action Learning Set (Led by NHSE)

Progress

Since the last Opioids Network:

Practices/PCNs

- We sent out an expression of interest for practices who wanted to trial Group Education Sessions (GES) for persistent non-cancer pain management
- Over 20 expressions of interest received
- 2 practices in NEL are trialing the GES and there is interest in NCL

Acute Trusts

- Audit on information included on discharge letters for patients newly initiated on opioid medication.
- Ideally all new prescriptions for opioids medicines should include specific indication, duration for use and review date or a plan for reducing/stopping.
- Current practices around opioids?

Group Education Sessions

Aim

- To support patients to explore methods for managing persistent non-cancer pain and provide information on the risks of long-term use of opioids.

Method

- Invite patients who have been on opioids for 3-6 months
- Practices will decide to have between 1-3 sessions with same cohort
- Survey to be completed before and after sessions to record any changes
- Ensure patient is seen by clinician either within the session or afterwards

UCLPartners is developing an implementation guide to Group Education Sessions for persistent non-cancer pain management.

Thank you

For more information please contact:

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Primary Care Workforce Survey Results

Jessica Catone, Project Manager for Polypharmacy

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Primary Care Workforce Survey

- Survey sent to primary care workforce in NCL and NEL (7th – 21st Sept 2022)

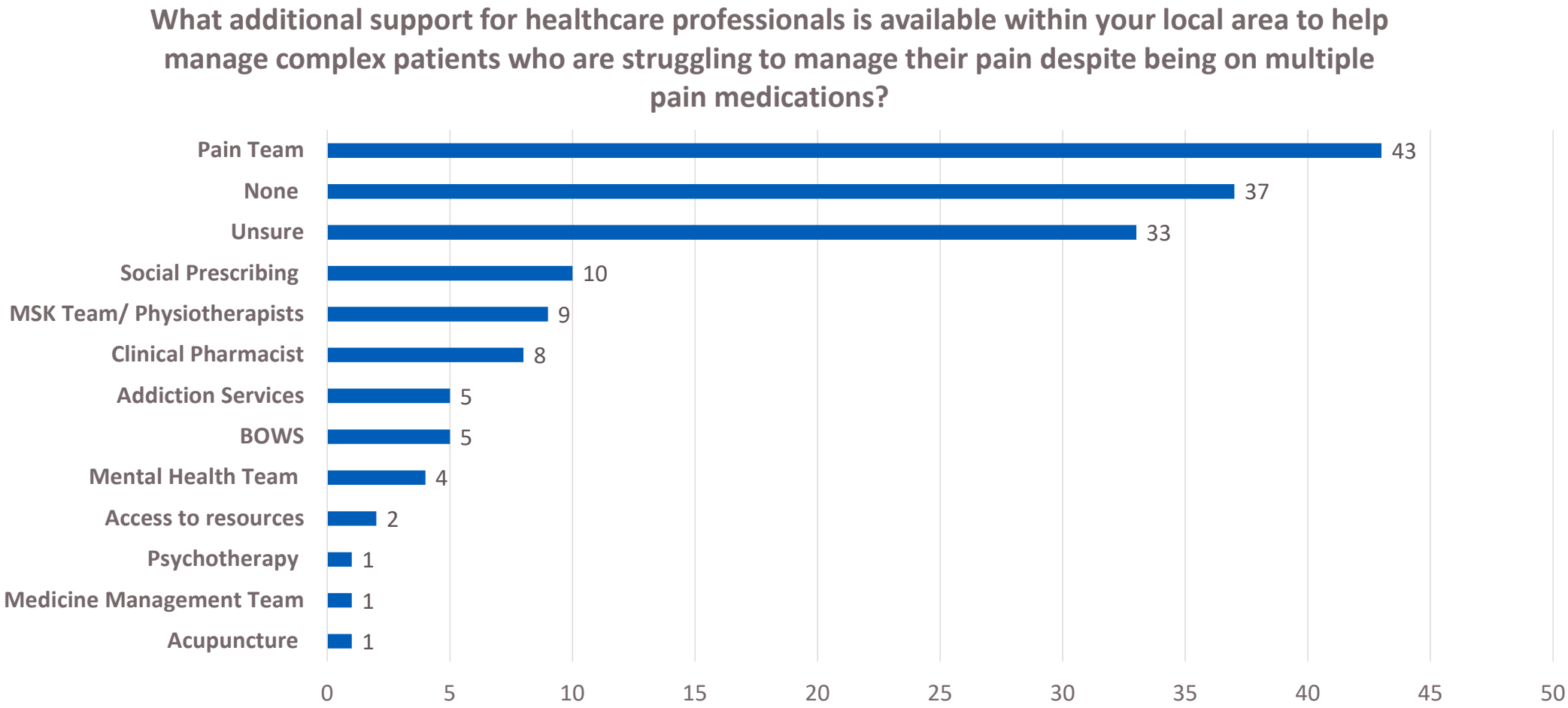
- 3 main aims – to identify:
  - Support available for healthcare professionals to manage persistent non-cancer pain e.g., specialist advice/online resources.
  - Services available that practices can refer patients to for support in managing persistent pain.
  - Barriers to deprescribing opioids for persistent non-cancer pain management.

Survey Results

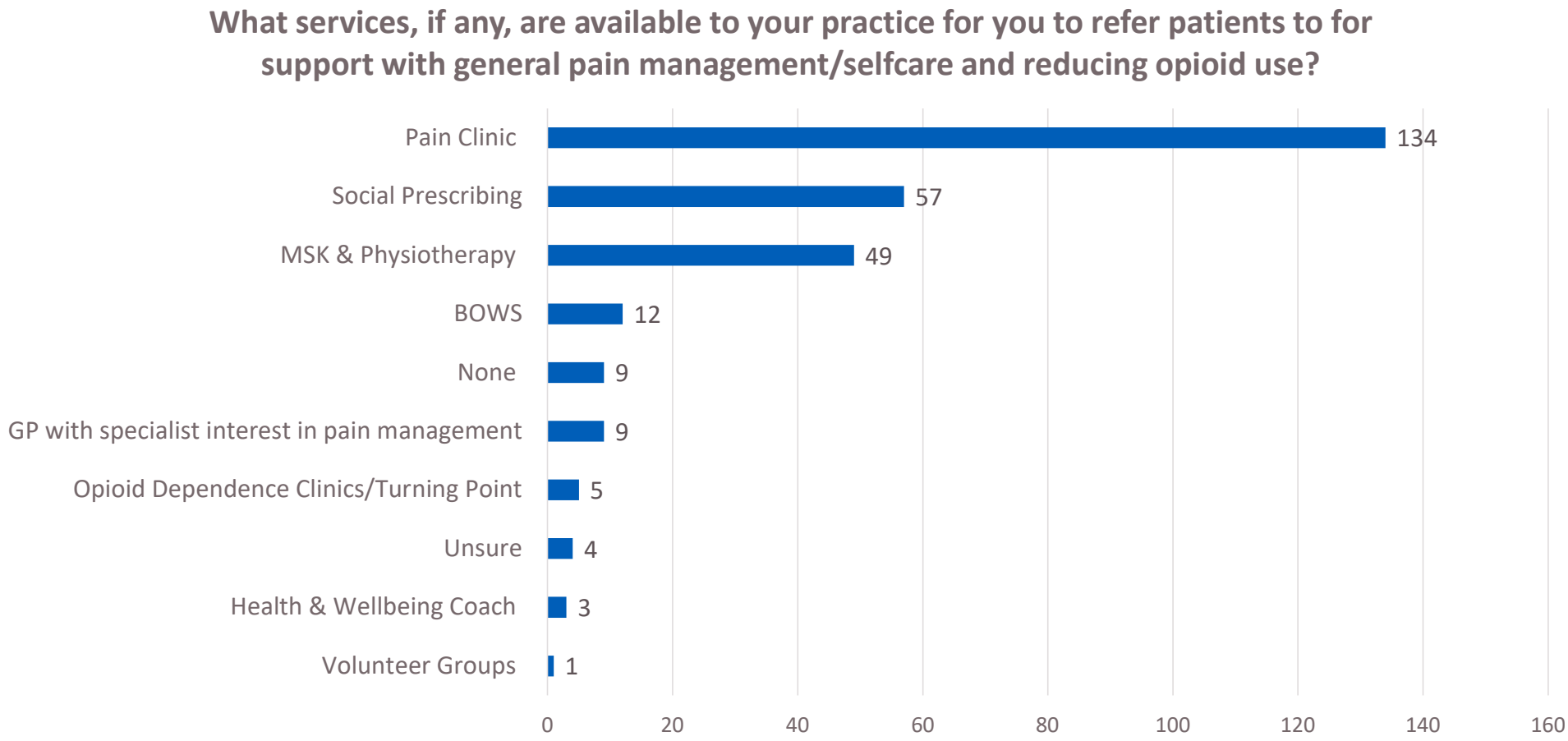
- 169 responses over 2 weeks
- 60% NEL; 40% NCL

Profession	Percentage	Number
GP	59%	99
Pharmacist	37%	62
Nurse	2%	4
Physiotherapist	1%	2
Other	1%	2

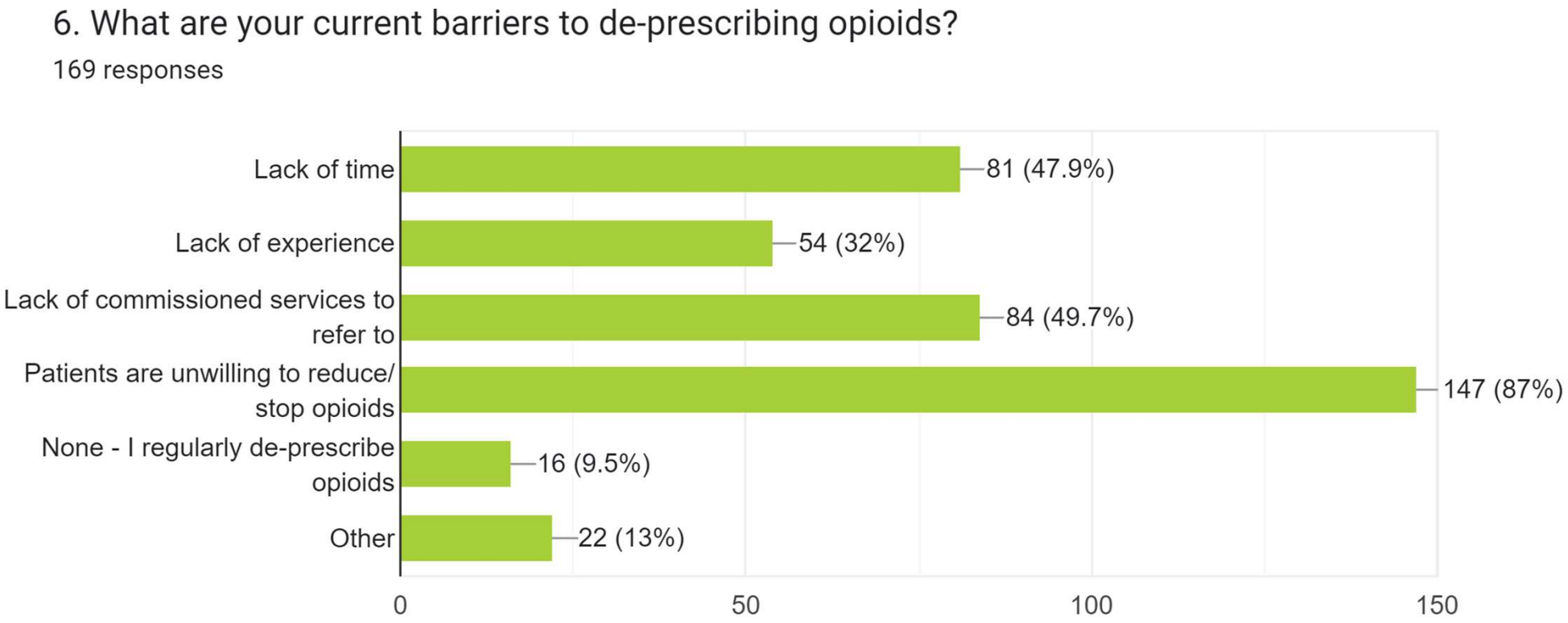
Support for Healthcare Professionals



Services Available for Referrals



Barriers to Deprescribing



Awareness of Resources

- Most respondents were not aware of online resources available that provide information on managing persistent non-cancer pain, like:
  - Live Well With Pain website
  - Opioids Aware website
  - PresQIPP e-learning modules

- PresQIPP is mostly used by pharmacists but can be accessed by other healthcare professionals.

- Contact your ICB Medicines Management Team for how to access PresQIPP modules.

Suggestions

- 34% of people suggested additional training and education.
- Other common themes were access to resources, opioid prescribing policy and the need for more collaboration across the health system, including:
  - Having access to/support from specialists or pain consultants
  - Receiving documented advice on when to reduce/stop opioids if initiated in secondary care/A&E settings

Other Comments

- Comments regarding pain clinics:
  - Need for quicker access to clinics
  - Clinics should be working to reduce opioid use
  - Clinics see chronic pain patients when they are designed to treat acute pain.

- Other comments included:
  - Information on pain management being provided as a link on their GP websites
  - Need for funding for this work
  - Need for better patient awareness around chronic pain and the dangers/drawbacks of regular opiate use

Resources

- Ten Footsteps to Living Well with Pain
- Pacing for Pain
- Pain Cycle
- Pain Management Guidelines from NHS Somerset
- Guide for Reducing Harm from Opioids from WEAHSN
- Video from Dr Dave Thomson (GP and Clinical Director in North Sheilds PCN)
- Opioid Use Change (OUCh)
- Ten Tips for Supporting Pain Self-Management
- Opioid Prescribing Resource Pack
- Opioids Aware website
- PresQIPP e-learning modules

Thank you

For more information please contact:

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NHS
University College London Hospitals
NHS Foundation Trust

uclh

Opioid stewardship within Acute Trusts

Amandeep Setra
Medication Safety Officer, UCLH

Background

University College London Hospitals
NHS Foundation Trust

CONTROLLED DRUGS NEWSLETTER

NHS South Region South West

SHARING GOOD PRACTICE IN THE SOUTH WEST

April 2017

SPECIAL EDITION – FAYE'S STORY

What can happen when things go wrong with prescribing for chronic pain – lessons that must be learned by all healthcare professionals

As told by her parents, Linda and Steve

Faye (right), when she was well

Our daughter Faye injured her back lifting an empty fish tank into a car boot in 2009. Her pain did not resolve, so she was referred for surgery in 2010. This did not go well, and she left hospital still in pain, on oxycodone. As her pain continued, the doses and numbers of medications prescribed increased. Faye put on 7 stone, and developed sleep apnoea, and then in June 2013, she developed diabetes. In September 2013 Faye had a respiratory arrest, and died – she was just 32 years old.

Before Faye injured her back, her life was pretty normal. She worked as deputy manager at a major pet store, and she was planning to get married, and start a family. She and her fiancé both had a horse, and a social life that revolved around this.

Following her operation in May 2010, Faye was taking 80mg oxycodone daily, and by June 2013, she was taking more than 200mg oxycodone daily, along with diazepam, amitriptyline, prochlorperazine, sertraline, diclofenac, esomeprazole and paracetamol. Gabapentin had been tried, and withdrawn. Her symptoms and health problems had become steadily worse as the dose of oxycodone increased, and more medicines were added in to manage the side effects. As well as the pain, she suffered from nausea, sleepiness, fainting, muscle spasms, blistering skin problems and depression. She had become a compulsive home shopper. Despite the prochlorperazine, her nausea was so bad she sometimes could not bear to use the CPAP face mask at night, for her sleep apnoea.

Whilst waiting inpatient rehabilitation (for 20 months), Faye had some sessions of cognitive behaviour therapy from the NHS counselling service, and also started a pain management course. She did show signs of improvement – she managed to lose 3 stone, started to look after her appearance again, and managed to go out for a walk with her Dad. We really thought that

she had turned a corner, and would finally start getting better. Then out of the blue, she had a respiratory arrest and died.

We believe that her death was avoidable, and that there are still a lot of people like Faye receiving unsafe treatment for long term pain, who are, at worst, at risk of dying suddenly, or at least, of leading a twilight life.

What went wrong?

How did our daughter go from having a normal life in July 2009, to dying suddenly in September 2013? Was the treatment she received to blame? The inquest did not supply the answers that we had hoped for, so we set about trying to find out for ourselves. There are several ways that her medicines could have been doing more harm than good;

- Her dose of oxycodone was repeatedly increased, against the advice of the pain clinic, and despite her pain not being effectively managed by it. It was way above the safe limit, now set at 120mg morphine daily equivalent dose (see Opioids Aware http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
- She was taking oxycodone with diazepam - opioid and benzodiazepine medications taken together can lead to respiratory depression, and she already had sleep apnoea https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm518110.htm
- Several of her medicines are known to increase the QT interval, especially in combination – long QT syndrome is a leading cause of sudden cardiac death in young, otherwise healthy people
- Diclofenac - there is a small risk of heart attack or stroke in patients taking systemic diclofenac regularly, especially at high doses (150 mg daily) and for long periods
- Erythromycin – just before her death, Faye received a course of erythromycin for infected in-growing toenails. There is a small risk that when taken with amitriptyline or prochlorperazine, erythromycin can increase the risk of an irregular heart rhythm. Although Faye was told to stop taking the amitriptyline and prochlorperazine whilst on the erythromycin, the long half-life of amitriptyline may not have been taken into consideration. On the day she died, Faye had texted a friend to say that the erythromycin was making her feel strange
- Faye may have had an allergic reaction to erythromycin – her face and upper body were very swollen after death

Any or all of the above could have contributed to Faye's death. Also, given that her MRI scan showed nothing clinically significant, should Faye have been offered the operation on her back? That seemed to make things worse too.

uclh

Faye's state of mind

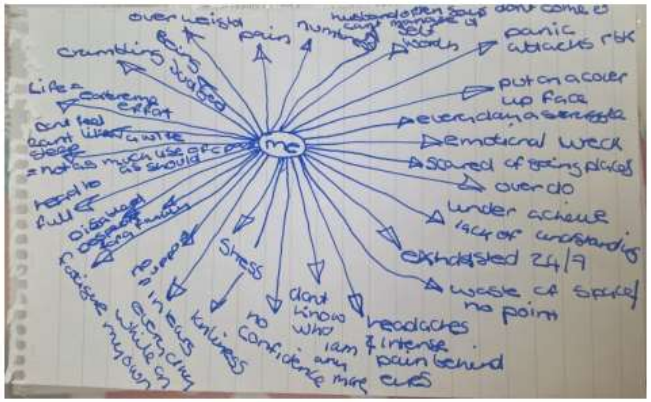
As a nine year old, Faye suffered from a nine month long period of intense pain and illness, which was diagnosed at the time as ME. It left her, as an adult, with a tendency to headaches and joint pains. We don't think that doctors treating her as an adult were aware of this.

Faye put herself under a lot of pressure to succeed in her plans. She was determined and ambitious. Her job was difficult and she worked very long hours. She had to go and look after her horse after work, and got home late most nights.

Faye did not smoke, rarely drank alcohol, and had a real aversion to swallowing tablets. She ended up taking 40-50 tablets a day, using fruit pastilles and grapes to help her swallow them.

When all of this started, if she had been questioned about her mood, and her past experiences of pain, would this have made the doctors think twice about giving her opioids? Or increasing the dose, when they were clearly not working?

Faye's mind map, which was found after she died



What could have been done differently?

Nobody should end up dying of a bad back, especially a young woman like Faye with her whole life ahead of her. Yet we know that there are a lot of people with bad backs, and other sorts of

long term pain. Many are still on high dose opioids, and medicine combinations which may well be doing more harm than good.

We discussed these concerns with the new larger GP practice, which has incorporated Faye's GP practice. They have given this a lot of thought, and have made the following changes, to try to avoid another person like Faye dying unnecessarily.

The GPs at the practice are now focusing on these key learning points:

- Safety issues around opiate prescribing
- The role of oxycodone, and an understanding of the dose equivalence of different opiates
- Alternatives to opiates for managing ongoing pain
- Mechanisms for reducing high doses of medication, e.g. weekly scripts, MDS
- Review of current prescribing in the practice
- Mechanisms for group discussions around difficult to manage cases, including a monthly patient safety meeting to review concerns about medication levels

We have thought about what message we want to send out ourselves, as grieving parents, and we believe that all healthcare professionals in every GP practice in the country should think about these points:

- First, do no harm
- Follow evidence based practice
- You have a duty of care
- Do not authorise prescriptions, even on specialist recommendation, if you don't think they are safe

Guidelines are published, and circulated, and yet change in practice is too slow, in the face of new safety evidence. What should your practice be doing differently, today? How could you spot another person like Faye, struggling and failing on their medicines, and save them?

Sue Mulvenna CD Accountable Officer 09.06.17

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Darren Barnett ☎ 0113 824 8813 or 07747 443418 darrenbarnett@nhs.net
Project Officers:
Samantha Hazell ☎ 0113 824 8129 samantha.hazell@nhs.net
Vicky Bawn ☎ 0113 824 8129 vickybawn@nhs.net
We can no longer receive or send faxes.

Round table discussion

- Key stakeholders from Camden, Islington & Haringey
- Eye opening comments
- Thoughts around those on less than 120mg morphine or equivalent
- Next steps……

Next steps

- Local GP audits – not only those on >120mg morphine or equivalent
- Focus in acute trusts on starting patients on opioids (post surgery)
- Quality of discharge information provided
- Opioid Stewardship Committee

Local audits

- Review of opioid naïve patients commenced on opioids

- Inclusion:
  - Opioid naïve
  - 2nd May – 15th May 2022
  - Discharged on any opioid

- Quality of discharge information:
  - Appropriate amount of supply?
  - Duration of treatment?
  - Clear plan for GP & patient?
  - Information provided to GP?

Preliminary results

- 304 patients identified
- 69 met inclusion criteria

- Split evenly between maternity, A&E and surgery

- Dihydrocodeine was most common opioid

- 0% of discharges provided clear information to healthcare professionals stating recommended dose, amount supplied and planned duration.
- 26% were supplied a duration less than 7 days
- No evidence of pain leaflets being provided

What can you do?

- Look at any patients who are discharged on opioids focusing on:
  - quality of information
  - amount of supply
  - suitability of opioid choice
- Teaching of non-specialists
  – doctors, nurses, pharmacists
- Medication Safety Committee priorities
- Other opportunities

Discussion – Miro Board

Aim: To understand current practice around opioid prescribing

Link to join: https://miro.com/app/board/uXjVPvW8bCQ=/?share_link_id=853354442770

Password: BumbleBee2023

Instructions

- Populate each table with what you think each sector is doing well and what they could improve on.
- Comment on all sectors even the one you work in. If you have done any projects or implemented any innovative ideas in your sector please document this in the third column. You can also include any suggestions you have for future innovations in your sector or in another sector.
- You can enter information in all boxes below but ensure you use:
- **GREEN** sticky notes if you are based in **Primary Care**
- **BLUE** sticky notes if you are based in **Acute Care**
- **PINK** sticky notes if you are from **Healthwatch**
- **YELLOW** sticky notes if you are from **community/voluntary sector or if you are a patient**

Feedback

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#6172 590

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How would you describe this event in one word?

ⓘ Start presenting to display the poll results on this slide.

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The duration of this event is:

ⓘ Start presenting to display the poll results on this slide.

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The best time for this event is between:

ⓘ Start presenting to display the poll results on this slide.

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We swapped breakout rooms for the Miro Board. What are your thoughts?

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Name one thing that you will implement to support reduction of opioids in your organisation?

ⓘ Start presenting to display the poll results on this slide.

Next Steps

Thank you for joining

For more information please contact:

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