**Opioids Aware; an audit of general practice prescribing patterns of high dose opioids for chronic pain; data from 74 practices (663,418 patients) within the East of England (NHS England Midlands and East (East)**

**Anonymised reflections from practices**

1. “All patients on high does opioid medication have been contacted for a face-to-face medication review with a GP. We have undertaken a housekeeping exercise to ensure that medication is linked with active problems so that indication for medication is clearly identifiable. Recently visited by community pain management team who have carried out an educational session with our clinical team. We have also completed comprehensive audit cycles on high dose opioids use and multiple opioid use with care plans now in place for specific patients.
2. Consider carefully prescribing gabapentin/pregabalin readily in patients on opiates and ensuring patients are regularly reviewed; particularly those on high dose opiates and those whom have evidence of misuse or overuse. Ensure notes clearly indicate reason for high dose opiates and indication is put on the repeat template below the drug.
3. continue to monitor use of opiates carefully
4. Assign each patient a designated GP; arrange initial treatment review and then amend repeat template to prompt 3 monthly reviews; ensure clear indication/problem read code linked with each medication; add reminders to home page alerting prescriber patient on >120mg morphine or evidence or overuse/misuse; re audit in 3 months
5. The 6 patients identified by the audit have been brought to the attention of their registered GPs. The clinical pharmacist will audit and review on all patients who are taking strong opiate analgesics including tramadol. To ensure all patients have a recent level 2 medication review on record. The audit will be repeated in 6 months as there are a number of patients on the cusp of 120 MEQs. Clinical staff, dispensary and reception team are to keep an eye on the frequency that opioid analgesia are ordered, especially instant release morphine and oxycodone. Early ordering, over ordering and any aberrant requests will be brought to the attention of the clinical pharmacist and GP. Guidance on prescribing opiates in chronic non malignant pain to be reviewed and distributed amongst the team.
6. We will consider auditing our use of gabapentin/pregabalin in addition to opiates as this seems to be an area of potential concern
7. Main change that needs to be made is regular medication reviews focusing on pain, this is definitely lacking. Re further information /support discussion and information. Perhaps some patient decision aids to use in reviews if possible.
8. Our changes will be as a result of the audit to discuss in a clinical meeting. We need to code the indication for px. Make sure we review these patients every 3 months and no co prescribing gabapentin and pregabalin unless advised by secondary care.
9. Increased awareness; 1 patient called for medication review; 1 patient not ordering gabapentin removed; 2 others under regular monitoring; 1 is palliative.
10. Continue to discuss patients in MDT meetings and both are on the case management list for regular MDT meetings. Prepare special patient notes for out of hours GP care
11. We are already undertaking an opioids audit via MOLES. (*Presented detailed review of each patient on high dose opioids not presented as potentially identifiable)*
12. Both patients will attend for an urgent medication review with a view to support a reduction in opiate use. This audit and useful links will be discussed at a meeting for all clinicians.

This audit prompted me to review all of our patients receiving opiates, and 2 patients have been identified that are on at least 2 different opiate preparations – dihydrocodeine and tramadol. These patients will also be reviewed. The practice medication review policy will also be updated to reflect that patients with chronic pain on >120mg morphine daily require regular reviews

1. We also checked how many patients out of the 19 have been referred to the pain clinic and 15/19 had had a referral-the GP is going to look into the other 4 patients’ records

Dr xxx will attend the workshop at the next Prescribing Leads Meeting

It was discussed and decided at our Clinical Meeting that we will send the patients letters inviting them in for an Opioid Medication Reducing/Review enclosing the Weaning Opioids leaflet for patients.

1. More robust medication reviews. Allocated specific medication review for opioids. Alert added to patients’ medical records to remind clinicians that patient needs a three monthly medication review.
2. We will examine the use of pregabalin and opioids. We already audit the use of high risk drugs on a 3 monthly basis and we will add into this audits of lover dose opiates and codeine

Further information – would be much appreciated thank you

1. Patient has Durogesic 50mcg patch = 120mg morphine daily. Rationale gen osteoarthritis, pain not previously controlled with diclofenac, coxibs, tramadol, morphine, 25mcg fentanyl patch and unable to tolerate buprenorphine due to motor restlessness. Uses regular QDS paracetamol alongside (WHO pain ladder)
2. Each GP has been advised of the audit being undertaken and asked to review and ensure they are happy with the patient’s’ current medication regimes and content with the correspondence received from secondary care to support patients’ pain management plans. Prescription clerks already highlight any potential problems with prescription requests and we work together to ensure patients are managed carefully with all teams and GPs within the practice. We will continue to monitor these patients on a regular basis and review their pain management with intentions to reduce/step down where possible.
3. To review regularly

19 (no patients on high dose opioids for chronic pain) We have always been concerned about excessive opiate prescribing - ever since I joined in 1993. I remember one man who had chronic back pain and (with the help of the pain clinic) wound up on truly epic quantities of opiates. We therefore regard opiates like we regard Naproxen and Pregabalin and Sertraline - as a necessary evil that can be used on occasion but need to be titrated down as soon as possible to the minimum necessary and in any case we try to step down at medication review.

20 (no patients on high dose opioids for chronic pain) The two Practices as a whole have seen significant improvement over the last 18 months in opiate prescribing, I guess I would contribute it to the following reasons:

-          Audit and Structure; I have only been in position for 18 months however historically the Practices only ever used to carry out ‘necessity’ audits. This led to reactive management of patient medications and management responding to MHRA alerts, national bulletins or NHS England requests. We have now developed and changed this way of thinking to provide structure and accountability to prescribing, making us proactive and ensuring that patient safety is paramount and the reason we carry out audit without external prompt. Thus, being evident that our opiate audits (attached) were carried out long before requested by NHS England.

-          The ‘Law’. The change in Driving Drug Law gave us leverage with our patients on high dose opiates – it became a topic for discussion, ‘did you know that the dose you are taking of morphine now means you are over the legal drug limit to drive?’. We were surprised of the benefit that this had on our patients who then went on to reduce doses to below <120mg per day.

-          Education and Knowledge; We used every external resource to come in and educate the GP’s on alternatives. The Community Pain Team came in at the beginning of our quest and then came back six months later. I feel it is important to continually refresh knowledge and opportunity to look at how referral pathways may have changed or adapted over 6 months (which can often be a lot in 6 months!). I provided patients with agreed reducing dose plans and they had access to telephone appointments with their GP if they felt they were struggling with the plan. I have also been able to give guidance to the Dispensing teams about opiates and appropriate dosing.

-          History; We have dealt with the majority of these patients as historic problems and therefore we have prescribing plans and policies in place to stop such prescribing escalating in the future.

I do not think our population differs from most surgeries – the populations between both of our sites are certainly very different but we come up against very similar prescribing issues for example. We are however, constantly monitoring and managing these patients, to ensure that we take accountability for the safe prescribing of their medication.

21 We have one patient on high dose opiates. We have been careful to monitor his use and is on 120mg daily with a maximum of 100mls oramorph on top of this per month. He does not order extra.

22 All patients on high dose opioid medication have been contacted for face to face medication reviews with a GP. We have undertaken a housekeeping exercise to ensure that medication is linked with active problems so that indication for medication is clearly identifiable. We have recently been visited by the community pain management team who have carried out and educational session with our clinical team.

23 The practice will review all patients on these medications at least every 3 months. We will also improve identifying the indications more clearly. The KISS *g*uidelines have been distributed to all prescribing clinicians*.*

24 Patient has been seen in xxxxxxxx and yyyyyyyyyyyy hospitals who didn’t manage to change opioid use in this lady

25 Increased awareness of this issue. Reassured that our current system shows we have reviewed all but one patient who is under pain clinic. Will be focusing on preg/gab prescribing over Apr 2018-2019

26 We discussed the results at our clinical governance meeting. We felt we were doing well to have so few patients, having made an effort in recent times to scale patients down. One of the two patients above is on a benzodiazepine as well but efforts to reduce the medication has proved very difficult. The key thing we all felt was that minimizing new patients getting into the group was the most important long term goal.

27 We have discussed and identified patients and have previously reviewed them all and will continue to do so. We will be inviting 4 of the patients identified for review soon.

28 To make regular reviews on all patients currently taking opioids

29 Awareness raising with GP colleagues regarding risks/require medication review 3 monthly for high dose opiate. We will recall these patients for review.

30 Things done well:

1. Clear and specific prescriptions are being issued with these patients, with frequency and dosages clearly documented
2. There is no co-prescription of Benzodiazepines for these patients
3. Where Gabapentin and Pregabalin is prescribed in our practice, the dosages do not exceed the cut-off above which can be hazardous when combined with Opioids.

Things that can be improved:

1. Clear indications for use of high dose opioids were not present for all the patients
2. Regular, appropriate reviews of opioid medications were not conducted for all of the patients. The medications were often re-authorised without a thorough assessment of their pain.
3. Inappropriate co-prescription of Z drugs was evidenced.

Changes proposed:

1. Updating the patient records on System 1 with the appropriate indication
2. Consider booking these patients in for a detailed review of their opioid medications, in view of reducing the dosage to <120mg/day. Exploring psychosocial/emotional issues would be important as part of this assessment
3. Review the need for Z drugs
4. Review the need for Neuropathic pain medication (such as Pregabalin and Gabapentin)

31 One patient would need urgent review. All 3 patients need regular review and reduce the dose if applicable.

32 We will make sure we carry out regular 3-monthly medicine reviews with a greater focus on co prescribing z drugs or benzodiazepines. We will monitor closely for possible overuse issues. Awareness raised with dispensary staff.

33 These patients are ongoing reviews with a view to reduce the dose of the opioids to <120mg morphine equivalent. Some have signed the opioid contract.

34 For clarity and good audit trail clinicians will endeavourer to link more medications to indication or to problem- this will be added to our 2018/2019 Prescribing Plan. Closer attention to 3 monthly medication review for patients on this medication – re-set re-authorisation schedules appropriately.

35 The GPs felt that this was helpful in highlighting patients on high doses of opiates; however, many are on these because other options have been exhausted or treatment has been initiated by the hospital It has highlighted a patient whose medication will be reviewed (pregabalin >600mg).

36 (one patient identified who is on gaba drugs) I will call him in for a medication review.

37 Given the results of the audit above, we’re taking two actions to improve our practices. Firstly, we’re sending reminders to GPs in the surgery to provide a clear indication for the opioid prescribed. Secondly we are modifying our prescription review template to help with the review of opioid prescriptions.

38 GPs and clinicians have discussed as team and are now more aware of co- prescribing. Clinicans aware of how to access e-learning for their CPD.

39 Will be offering patient referral to community pain clinic. This highlights again the risks and dangers but those patients on high doses/multiple co-prescribing are usually under pain clinic/other clinics, also with complicated co-morbidities and so a difficult task.

40 Try to encourage above patients to reduce level of opiates.

41 Clearly identify indication for opioid use; monitor patients who over use/misuse regularly- set up proper treatment withdrawal plans; medication reviews of opiates – should be carried out regularly; avoid co prescribing z drugs and benzos; review the patients on high dose pregabalin (safety issue identified); avoid oxycodone/naloxone(Targinact) in chronic pain management. Oxycodone highly addictive and very difficult to stop escalation of dose once patient on this drug.

42 There are some people who seem to have slipped into having >120mg morphine equivalent/ day almost by accident with a mixture of opioids prescribed. I think these would be the first people to encourage to reduce their prescriptions as they also may not be aware of how much they are taking (for example people on low doses of oxycodone but remain on regular codeine, or when liquid preparations are added in). For others, often those without a clear indication, I think we need to invite them in to start discussing their prescriptions and perhaps address some of the adjuncts which are risky (e.g. the co-prescribing of pregabalin and gabapentin with morphine) and negotiate something to reduce. Referral to the pain clinic would also support this so engaging patients in this would help.

43:: review audit on a regular basis to monitor vulnerable patients

44 Dr xxx will review all patients identified in the audit to see if he can further reduce the pain relief required.

45 Dr xy has reviewed all case notes and where appropriate has either asked registered GP to review and document medication review with the patient or arranged a medication review with the clinical pharmacist, CP, who will review and discuss with the patient about reducing the dose of morphine. Indication for opioid could be improved.

46 **FINDINGS :**

1.Indication not obvious from medical summary page on some of patients. Needed to go into correspondence to find out why—even letters from pain clinic failed to give clear reason –often stating “chronic pain”-- main reasons are chronic pain from ME/CFS/fibromyalgia/Back pain /localised pain—e.g. groin /hypermobility

2. Approx. 10 patients had been by pain clinic—and doses suggested by them

3. Nil evidence from S1 re over/under ordering—use

4. Only 4 patients recorded as having rev re CD on rpt screen

5. 2 pts on regular Z drugs

6. Nil co-prescribing of benzos on rpt screen

7. 7 pts on either gaba/pregabalin –not nil exceeds max dose

**What changes will you/your practice make as a result of this audit?—audit discussed at partners meeting on xx**

* *Better documentation of indication on summary and on drug label*
* *Reminder on front of notes put on to state on high dose opioids*
* *Better rev of cd drugs and documentation –also for pts on high dose opioids—limit review to every 3 months /3 issues*
* *Rev pt to see if dose can be lowered in time*
* *Should NHSE /CCG—be investigating more in psychological intervention at pain clinic level as well*
* *Need to treat opioids like any other high risk drug*
* *The key message is DON’T START OPIOIDS. We should broaden our approach to chronic pain – the drugs don’t work. But, if we do prescribe, we should avoid high-risk doses.*

47 GP learning, aim for more frequent medication reviews for those patients on opioids

48 The results will be/have been shared at a clinical meeting and agreed that all CDs should be linked to problem on the medication page on EMIS, there should be a minimal time between repeat orders to prevent misuse, patients should have regular reviews and meds not updated for more than 6 repeats [sic].

49 Of the 18 patients identified by the search on >120mg morphine equivalent per day for chronic pain, 5 patients had the controlled drug on their repeat medications. In all 5 patients, the controlled drug had not been reviewed by a GP in the last 3 months due to the medication being on their repeat medication list, which can mean that the patient is sometime not reviewed for up to 6 months. One action that the practice will make as a result of the audit is to remove all controlled drugs from patients’ repeat list. Prescribing the controlled drug on an acute basis will ensure that a GP reviews the prescription prior to it being issued to patient and hopefully will identify those who are possibly overusing the controlled drug or are due a review with a GP to discuss a reduction in their dose.

Prior to completing the audit, I had been unaware of the risks of combining opioids with pregabalin or gabapentin. All 5 patients who are being co-prescribed gabapentin or pregabalin are on relatively low doses but as a result of the audit, they will be invited to see a GP at the practice for a review to discuss discontinuing the gabapentin or pregabalin. In 3 of the patients’ records, a GP had documented in the past that the patient felt that the gabapentin or pregabalin they were taking was ineffective for their pain anyway.

One of the difficulties encountered by GPs at the surgery when dealing with patients with chronic pain is the lack of a pain management service in YYYYY that offers a holistic approach to treatment. From my own personal experience, when patients on high doses of opioids have been referred to pain services out of area, the advice given to GPs is often to de-prescribe but there is little support in place for clinicians on how to achieve this and also patients report that they feel unable to reduce due to being unable to cope with their pain. YYYYY CCG has recognized this and have commissioned a community pain management service, which is due to start later this year and will offer psychological intervention alongside de-prescribing to help patients develop coping mechanisms. In the meantime, the surgery has begun to review patients on >120mg morphine equivalent with the aim of trying to reduce the dose that they are currently taking. As a support for GPs when discussing reduction of the opioid dose, the practice based pharmacist from the CCG has agreed to sit on these consultations and re-iterate to the patient, the risks of continuing on a high dose.

50 Completing this audit has raised awareness of this issue among prescribers and allowed GPs to reflect on their own prescribing in this area.

51 Although several patients had not had their medication reviewed within 3 months, they had been on stable medication for a long time. This has raised awareness about combinations of opioids and gabapentinoids – one patient already had his dosages reduced so he was not picked up by the audit. Nearly all the benzodiazepine use can be justified clinically. Most of these patients have significant symptoms and have been investigated/treated by pain clinic/neurologist etc. It is hard to see how we can otherwise manage their symptoms. I will review the KISS documents and discuss at clinical staff meeting.

52 The practice participates in local prescribing quality initiatives. One of these is pain management. Audits are regularly undertaken e.g. pregabalin prescribing, prescribing of 2 or more opioids. Actions following these have ensured our prescribing is low and evidence based. All clinical staff have undertaken on line training into the management of acute and chronic pain as part of the prescribing incentive scheme. Patients are advised on registration that all potentially addictive medication will be reviewed and a plan put in place to reduce and discontinue prescribing where appropriate.

53: A search on SystmOne revealed 11 people on >120mg morphine equivalent per day. Six patients are under specialist care and meds initiated and are under appropriate review by the specialist team. Five patients reviewed, medication reviewed. Plan in place to attempt alternative if appropriate. Patients are aware of need for regular review regarding these medications. Further specialist referral completed where appropriative. Each case assessed individually and action plan initiated.

54 I have identified one patient on large doses of several drugs, who has not attended for review, there is evidence that he is aggressive. I will investigate how best to manage him.

We may need to do further searches to identify others.

2 patients on this list have advanced cancer.

1 has back pain, 1 has bowel problems 1 has neurological and mental health problems

55 These patients have a number of complex pain issues from varying origins. Those patients who have not had a review in the last 3 months will be called, reviewed and referred to the pain team as appropriate. Will encourage GPs to add indication onto the action repeat template script to make indication much clearer.

56 We are writing to each patient, inviting them in for a review with our clinical pharmacist.

1. We have developed (in association with colleagues in ZZZZZ CCG) an opiate management “bundle” which has, all in one location, information for safe prescribing of opioids. This includes patient information, prescriber information, advice for patients about weaning down doses of opioids and a treatment agreement for all people prescribed opioids.
2. With regard to the patients identified by this audit, at the review, we will be discussing the evidence surrounding the lack of efficacy for opioid doses greater than equivalent of 120mg morphine daily, and the increased risk of harm at these doses.
3. We will then draw up a slow plan to titrate down each patient to an effective, safe dose. We will offer support to each patient, for example referral to the pain team or suitable secondary care to help with this.
4. We have had a meeting between all the clinicians and agreed actions if any patients do not engage in a slow down titration to a safe dose. We have also discussed this with the CSU prescribing lead.
5. The audit has also helped us to identify “at risk” patients – those who currently are prescribed regular quantities of opioids for chronic pain whose current daily dose is less than 120mg equivalent morphine. Historically these patients may have, in time, had their doses increased above the 120mg threshold. Now that these patients have been identified, we can actively manage their pain more safely.
6. We will be repeating this audit at regular 6 monthly intervals.

57 This is quite scary. Our figures represent about 0.15% of the practice population which is in line with the National figures. We plan to review each of these patients and start a dose reduction to within safe limits. This will start after a more extensive practice discussion, agreeing a plan and allocating named GP’s to the patients. There is likely to be a significant number of patients on Opioids at dose lower than 120mg for similar indications, these patients will also need a proper medication review. To run parallel with this we will provide education about Opioids to try to alter prescribers’ habits.

58 The audit helped to identify the patients who are on high dose of opiates. This has helped us to identify the practice prescribing trends of opiates along with combination of benzodiazepines, pregabalin and gabapentin. None of the patients are on exceeded dose of gabapentin and pregabalin. Excluding the palliative care patients, after reflecting on the prescribing trends at XXXsurgery, following changes can be made as a result of this audit with patient engagement.

Firstly, Contact the patients who are on high dose opiates, along with combination of gabapentin and pregabalin and arrange an appointment to review the usage of opiates and their pain management. Outweigh the potential risk and benefits to the patient on the usage of high dose opiates. Explain to patients, the rationale for stopping opioids including potential benefits of opioid reduction. Review the use of high dose opioids with pregabalin and gabapentin and make necessary dose adjustments based on patient’s pain threshold. Gradually reduce the dose to see if the pain threshold is controlled and advise on pain management. Closely collaborate with patients, carers and other members of patient’s health care team and agree shared care and monitoring patient’s usage. Document the relevant key findings that support the decision to prescribe opioids and highlight the agreed outcomes of the therapy.

59 No patient has these medications on repeat – close supervision of each issue by the GPs. Pregabalin use was usually either by MH or pain team. Limited use of benzodiazepines for pain. Indication always clear and the need is appropriate. All patients who have not had a review in the past 3/12 will be called back for a review”