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NHS England & NHS Improvement – Midlands Controlled Drugs Newsletter

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This newsletter contains local and national CD information to support safe use and handling of controlled drugs. You can use the dedicated e-mail to contact us: Shropshire & Staffordshire e-mail: england.shropshire-staffs-cd@nhs.net Derbyshire & Nottinghamshire e-mail: england.nottsderbycontrolleddrugs@nhs.net

Report ALL CD incidents, concerns and occurrence reports via the CD on-line reporting tool: www.cdreporting.co.uk

Sean's Story

A film from NHS England aims to highlight the dangers of over-prescribing of opioids for chronic pain and shows how a patient, Sean Jennings, from Cornwall changed his life with other treatment.

Opioids are often prescribed for patients to deal with long term pain and recent studies have challenged the appropriateness of the levels of prescribing. There is little evidence to show that they are helpful for long term pain, their use will be monitored more closely now that the harms of prescribing these types of medicines are better understood.

'Sean's Story' is a video that tells the story of Sean, who had a hernia operation 25 years ago and due to an infection, ended up suffering chronic pain. For many years, he was taking large doses of opioids which resulted in numerous side effects and yet he still suffered from continued chronic pain. The film shows how long-term use of high-dose opioid prescribing had a devastating impact on his quality of life and how when he recognised he wasn't functioning properly, he sought help from his GP and was placed on a pain management programme, he found the long-term coping strategies for living with long term pain and non-drug therapy have been life changing.

One aim of the film is to encourage medical professionals to consider incorporating psychological therapies into their patient's care when prescribing opioids, to highlight the over-medication of some patients and to consider referrals to pain management courses which are widely available.

Sean's Story is available on NHS England's YouTube channel:
https://www.youtube.com/watch?v=BnJHJ9ZlJjY&feature=youtu.be

NICE Consultation

Consultation on the draft NICE guideline, Cannabis-based products for medicinal use, is due to take place imminently.

The plan, review questions and search strategies for this guideline have now been published on the project **web page**.

This information is published for transparency, and to enable stakeholders to prepare for consultation. For any queries please contact **CannabisMedUse@nice.org.uk**

Pregabalin and Gabapentin Dispensing Errors

On the 1st April 2019 Pregabalin and Gabapentin both became Schedule 3 controlled drugs. However, since this date we have been made aware of multiple dispensing errors in our region, where patients who have been prescribed Pregabalin and have been dispensed Gabapentin and vice versa.

The NPA Medicines Safety Officer Report January—March 2019 has highlighted that this is one of the more common Look Alike – Sound Alike (LASA) errors that are reported.

Pharmacists and dispensers are reminded Always to carefully check the product name and strength. Consider minimising selection error risks through: physical separation, visual warnings, shelf edges, and PMR prompts.

Opioid Patch Guidance for Health Visitors / Midwives

Following the release of the MHRA Alert on Transdermal fentanyl patches: life-threatening and fatal opioid toxicity from accidental exposure, particularly in children, the Staffordshire Medicines Safety Officer Network have developed some guidance aimed at clinicians who work with children and their parents to raise their awareness of the risks to children of accidental exposure to fentanyl.

The guidance is available to download on the online CD reporting tool www.cdreporting.co.uk under the newsletter section.

Gabapentinoids and Suicidal Behaviour

As you are aware Gabapentinoids became a Schedule 3 CD in April. Although it is widely reported that prescribers are trying to cut down on the number of prescriptions, there is an illicit market in Pregabalin.

thebmj A recent editorial in the BMJ comments on a 12 year large scale study (data from 200,000 prescribed in Sweden) looking at long term harms from Gabapentinoids. While in treatment there was an increased risk of suicidal behaviour and death from suicide, unintentional overdose, head and body injuries and road traffic accidents.

Pregabalin, but not Gabapentin was associated with a increase in violent crime. The editorial can be found at: https://www.bmj.com/content/365/bmj.l4021

A free downloadable booklet is available for professionals working with Pregabalin users, produced by DrugWatch in Northern Ireland and can be found at: http://www.drugsandalcohol.ie/27675/1/Pregabalin_Guidance_Booklet.pdf

ACMD Report on Ageing Population of Opiate Users

A recent report by the ACMD on the ageing population of drug users, states the number of opiate users over 40 years old in treatment has increased from approx. 25,000 in 2006 to more than 75,000 in 2018.

On the one hand this is positive news, in that the number of younger opiate users is decreasing, but on the other, apart from the role of an ageing population in the increase in drug related death, the report indicates that drug services face challenges in managing the complex needs of this ageing cohort.

A copy of the report can be found at: https://www.gov.uk/government/publications/acmd-report-ageing-cohort-of-drug-users

Medicines in Health and Adult Social Care

The CQC have published a report sharing the learning from risks and good practice in medicines optimisation that they have found from their inspections. From their analysis, they categorised the most common areas of risk with medicines across regulated health and adult social care services.

Medicines optimisation is the safe and effective use of medicines to enable the best possible outcomes for people. It also looks at the value that medicines deliver, making sure that they are both clinically and cost effective, and that people get the right choice of medicines, at the right time, with clinicians engaging them in the process.

You can find the report along with suggested actions for all health and social care providers via the link above, or via the CQC website: www.cqc.org.uk

Security of CD Keys

There have been a number of incidents reported across the country of CD cabinet keys reported as missing, particularly in hospitals. General measures for CD key security include:

- CD cupboards must be kept locked when not in use, the lock must not be common to any other lock in the hospital, keys must only be available to authorised members of staff
- The key-holder must be readily identifiable with arrangements for keeping the keys secure at all times. This is particularly important for areas that may not be operational at all times.

Key Messages

- View Sean's Story
- Pregabalin and Gabapentin LASA dispensing errors
- Medicines in Health and Adult Social Care Report
- Gabapentinoids and suicidal behaviour
- 31st August - Overdose Awareness Day
- Report ALL CD incidents, concerns and occurrence reports via the CD on-line reporting site: www.cdreporting.co.uk

International Overdose Awareness Day

International Overdose Awareness Day is a global event held on 31 August each year which aims to raise awareness of overdose and reduce the stigma of a drug-related death. Information on local activity, and downloadable resources such as posters and fact sheets are available free of charge to print and display in your organisation from:

https://www.overdoseday.com/