Safe Prescribing of Controlled Drugs Procedure within the KMS CAS IUC 111

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1 Statement of Aims and Objectives

1.1. South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is committed to providing high quality patient care.

1.2. The Medicines Optimisation (MO) Strategy guides the development of medicines optimisation within the Trust. Medicines optimisation ensures that service users/patients receive the right choice of medicines at the right time and are fully engaged in the process. The MO strategy strives to ensure that clinically effective and cost-effective medicines are prescribed in a patient- centred approach that safeguards patient outcomes.

1.3. This procedure is applicable to all clinicians (medical doctors, paramedics, advanced nurse practitioners, nurses and pharmacists) working in or on behalf of the Trust. It outlines a scope of practice and responsibilities in the safe prescribing of controlled drugs (CDs), some of which are also called dependence forming medicines (DFM), to which clinicians must adhere.

1.4. This procedure aims to equip SECAmb employees with the knowledge required to recognise requests for CDs, to manage drug seeking behaviour (DSB) and to minimise risks associated with the use of CDs. This policy will be integrated in practice alongside an educational and training programme that will support call handlers to recognise requests for medicines that pose a risk of harm associated with medication overuse, misuse and addiction and to know the relevant signposting required for service users.

1.5. This procedure aims to safeguard clinicians with guidance for dealing with requests for CDs whilst working within the Integrated Urgent Care service (IUC) and regularly auditing this practice against SECAmb policy and legal requirements alongside supporting reflective practice for prescribers.

1.6. This procedure aims to ensure the Trust is contributing to the national effort to reduce the inappropriate prescribing of CDs, and to provide assurance to the Trust board and the Medicines Governance Group that the safe prescribing of CDs is being prioritised in the Trust.

2 Principles

2.1. This document has been developed to address some of the issues surrounding the prescribing of controlled drugs (CDs), with due consideration for patient needs or preferences, including prescribing associated with remote consultations.

2.2. Drug seeking behaviour (DSB) is on the Trust Issues Register.

2.3. It is recognised that addressing the issues that arise from the prescribing of or withholding prescribing of CDs is complex, and requires a whole system approach, with participation across all healthcare systems including the IUC service.

2.4. SECAmb has a responsibility in supporting patients to make positive healthcare decisions at every interaction, including contact with the Kent Medway and Sussex (KMS) 111 CAS service.

3 Scope

3.1 This document is relevant to all workers contracted by SECAmb, including bank and agency staff, who answer medicines related calls and queries, triage/signpost patients, prescribe and administer medicines. It outlines responsibilities in relation to managing both 'legitimate' medication requests and DSB, as well as promoting safe prescribing of CDs, some of which are DFMs, such as benzodiazepines (e.g. diazepam), Z drugs (e.g. zopiclone), opioids (e.g. morphine) and gabapentinoids (e.g. gabapentin).

3.2 At all times, for controlled drug requests, prescribers are advised to:

- Verify patient identification
- Act within their scope of practice
- Document decision making
- Provide consultation feedback to the patient's regular healthcare provider
- Datix any concerns

4 Definitions

4.1 Datix (DCIQ) is the Trust's incident management system.

4.2 Dependence is an adaptation to repeated exposure to dependence forming medicines (DFMs) or controlled drugs, usually characterised by tolerance and withdrawal. Dependence is an inevitable (and often acceptable) consequence of long-term use of CDs and DFMs (examples are provided in appendix B)

4.3 Frequent Caller (FC) is defined as someone who makes 8 or more calls in a month, as per the Integrated Urgent Care Service Specification (add link to policy-update currently under consultation).

4.4 Drug seeking behaviour (DSB) is a defined as the intent of searching for a drug when it is not readily available. It is a pattern of behaviour that can signify drug addiction or drug use/abuse. All suspected DSB must be reported via datix (see DSB process- in draft)

4.5 Graphnet is the platform that is being used to provide Integrated Care System (ICS) providers with access to the Kent & Medway Care Record (KMCR) and the Surrey Care Record (SyCR)

4.6 Kent & Medway Care Record (KMCR) is an Electronic Health Record linking system that provides a read-only summary of that data to a health or social care professional when required for the purpose of providing health and social care.

4.7 Pathways Clinical Consultation Support (PaCCS) is an aide memoir for clinicians performing remote clinical consultations. It provides NHS Pathways content in a consultation format.

4.8 Special Patient Note (SPN) is information recorded about a patient with complex needs and may be used to document DSB concerns and management plans.

4.9 National Care Record Summary (NCRS) (formerly known as the Summary Care Record) is a national database created from GP medical records. It holds electronic records of important patient information such as current medication, allergies and details of any previous adverse reactions to medicines. It can be seen and used by authorised staff in all areas of the health and care system involved in the patient's direct care with the patient's consent. Primary care teams are encouraged to document DSB concerns within this document if it has been discussed with the patient.

4.10 Tolerance is neuroadaptation arising from repeatedly taking some medicines, such as CDs, in which higher doses are required to achieve a desired effect.

4.11 Withdrawal is a physiological reaction that occurs when a medicine such as a CD has been taken repeatedly is removed.

4.12 POM is a prescription only medicine.

4.13 Controlled drug: The term 'controlled drug' is defined by the Misuse of Drugs Act 1971 as 'any substance or product for the time being specified in Part I, II or III of Schedule 2 of the Misuse of Drugs Act 1971'. Controlled drugs are subject to strict legal controls and legislation determines how they are prescribed, supplied, stored and destroyed. Controlled drugs are managed and used in a variety of settings by health and social care practitioners and by people who are prescribed them to manage their condition(s). Controlled drugs are closely regulated as they are susceptible to being misused or diverted and can cause harm. To ensure they are managed and used safely, legal frameworks for governing their use have been established.

4.14 Controlled drug scheduling: The misuse of drugs regulations 2001 divided controlled drugs into five Schedules, each specifying the requirements governing such activities as import, export, production, supply, possession, prescribing and record keeping which apply to them.

5 Responsibilities

5.1 The **Chief Executive Officer** (CEO) is accountable for medicines used and the Governance of systems within SECAmb.

5.2 The **Chief Medical Officer** (CMO) through delegation by the CEO, has overall responsibility for medicines governance system design and overall assurance. The Medical Director has responsibility for the implementation, review, and thus revision where required, of this procedure.

5.3 The **Chief Pharmacist** (CP) is the professional medicines governance lead for the Trust and is responsible for producing robust systems and processes which comply fully with legislation, national guidance and regulatory requirements to ensure the safe and effective management and use of medicines throughout the Trust. The CP supports the CMO and EDO in providing professional pharmaceutical advice with regards to all medicines related policies, procedures and practices.

5.4 The **Executive Director of Quality & Nursing** has responsibility for matters relating to regulatory compliance, risk management, health and safety relating to this procedure.

5.5 The **Executive Director of Operations** (EDO), through delegation by the CEO, has overall responsibility for the implementation, operation and local assurance of this procedure. The EDO has overall responsibility for holding his/her staff to account for any deviations from this procedure and is responsible for the operational compliance of this procedure.

5.6 **Operations Managers** (clinical) are responsible and accountable for ensuring this procedure is adhered to within their settings.

5.7 The **Medicines Governance Group** (MGG) is responsible for monitoring the ongoing effectiveness of this procedure through audit and safety reports.

5.8 **The Non-Medical Prescribing Group** (NMPG) provides overarching multidisciplinary leadership for non-medical prescribers (NMPs) within the Trust. In doing so, it manages the process of Trust approval to train as a NMP within the context of service flow, improving patient access to medicines. The NMPG aims to strengthen and monitor the governance issues associated with NMPs and reports exceptions relating to NMPs to the MGG.

5.9 The **EDO, CMO and CP** are responsible for escalating unresolved concerns to the MGG.

5.10 The **Controlled Drug Accountable Officer** (CDAO) is responsible for the safe and legal management and use of Controlled Drugs (CDs) within the Trust, including recording, investigating, co-operating and sharing information relating to concerns about CDs to the CD Local Intelligence Network (CDLIN).

5.11 **The Medicines Safety Officer** (MSO) supports local medication error reporting and learning. The MSO acts as the main Trust contact for NHS England and Medicines and Healthcare Products Regulatory Agency (MHRA).

5.12 **Health Advisors** (HAs) support the prescribing process by identifying CD requests and then referring patients to either Pharmacy First (for non-CDs) or the 111 CAS prescribers (for CDs). This will be facilitated by use of the dm&d tool to search for medications as this categorises drugs into CD schedules and also referring to the Home Office list: List of most commonly encountered drugs currently controlled under the misuse of drugs legislation - GOV.UK.

5.13 **All SECAmb employees** who receive requests for medicines or prescribe medicines are professionally and personally accountable for complying with this procedure.

5.14 **Prescribers** are also responsible for reporting any concerns identified such as DSB via Datix (DCIQ) and appropriate documentation in the patient's clinical notes for safe and appropriate information sharing between CAS and primary care/GP practice, and for the safe and secure prescribing of CDs.

6 Education and training

6.1 This policy will be integrated in practice alongside an educational and training programme that will support call handlers to recognise requests for medicines that pose a risk of harm associated with medication overuse, misuse and addiction and to know the relevant signposting required for service users requesting CDs.

6.2 All prescribers will be supported by auditing of their practice, clinical supervision and reflective feedback. Prescribers are encouraged to attend educational NMPG meetings to discuss patient cases and to attend DSB meetings if invited following a Datix report.

7 Appropriate prescribing of CDs in the KMS 111 CAS

7.1 As per the NHSE IUC Service Specification, the IUC CAS should provide appropriate healthcare to patients in need of medicines and utilisation of NCRs to ensure CD requests are genuine and have previously been prescribed by primary care/GP practice. This includes prescribing medication when appropriate to do so, including CDs. This is reinforced by the BNF which in regard to dependence risks states that 'this is not a reason in itself to avoid their use'. The General Medical Council (GMC) standards on remote prescribing for CDs emphasise that safety checks are required to support safe prescribing of CDs such as robust identity checks to make sure that the medicines are prescribed to the right person: Controlled drugs and other medicines where additional safeguards are needed - professional standards - GMC (gmc-uk.org)

7.2 The UK Health Security Agency emphasises this principle in stating that 'It is really important that doctors do not inappropriately limit medicines, as this may increase harm, including the risk of suicide, and lead some people to seek medicines from illicit or less-regulated sources.'

7.3 It is also important to have safeguards in place to minimise the risk of harming patients with DSB in prescribing CDs, as per the Health and Social Care Act 2008.

7.4 A process that assures both principles mentioned above is illustrated in Appendix A- 1a Processing repeat prescription requests for CDs and 1b Prescribing CDs decision aid.

7.5 DSB involves false reporting of symptoms for the purpose of obtaining a CD in order to maintain a dependence on drugs. Tolerance and dependence associated with use of a CD beyond 4 weeks can compromise the safety of CDs for patients. Patients with DSB are likely to utilise out of hours services such as the CAS to obtain medicines associated with dependence. These include opioids, benzodiazepines, 'Z-drugs' and gabapentinoids, as summarised in Appendix B.

7.6 **Risk factors for DSB** can include any of the following scenarios:

- History of mental health disorders, drug dependence, alcohol or substance misuse
- Prescribed high dose/potent opioids
- On multiple CDs e.g. opioids and benzodiazepines
- Long-term prescribing of opioids for non-cancer conditions
- No evidence of a medication review in the last year

7.7 Recognising drug seeking behaviour (DSB)

7.7.1 Patients with DSB are not always easy to detect, particularly with remote consultation, as they do not always fit the assumed stereotype and could have any socioeconomic status. Video consultations and requesting identity from callers will reduce this risk.

7.7.2 Research has identified some signs of DSB. Whilst these are not definitive and require clinical assessment, they include a patient's:

- Reported loss or misplaced prescription
- Frequent requests of out of hours prescribing (≥8 calls/1 month)
- Medical records showing:
  - Use of multiple agencies to obtain prescriptions including the internet (this may be visible on care records e.g. NCRS, KMCR)
  - Multiple allergies e.g. to non-opioid analgesics
  - Taking more than the prescribed dose/requesting a repeat to early
  - Taking medication prescribed for someone else

  - Reluctance to answer questions about presenting complaints or medical history
- Extraordinary knowledge of the class/drug that is being requested
- Resistance to other therapeutic options without convincing rational
- Stating that they have just moved into the area
- Inconsistent symptoms or complex problem
- Aggressively asking for a CD, making threats, or implying consequences for non-supply

The behaviours listed above have a hierarchy of importance, and this guidance supports decision making around not prescribing CDs in individual circumstances (see Appendix A 1b decision aid for prescribers).

7.8 Risks of inappropriate prescribing of CDs

7.8.1 The Trust recognises that CDs can have adverse consequences both to the patient and the wider community. These include:

- Increasing the availability of CDs in the illicit drug market
- Increasing the risk of drug dependence, overdose and drug related crime
- Withdrawal symptoms and exacerbation of depression and anxiety
- Reluctance to explore safer alternatives to CDs

7.8.2 It is important to empathise these risks with patients exhibiting DSB, who are often vulnerable and may not understand all the risks their behaviour poses.

7.8.3 Patients exhibiting DSB are referred to their GP for a review, a datix report submitted and a management plan commenced that may include escalation to CDAO.

7.9 Safe prescribing recommendations for CDs

Always ensure you have sufficient knowledge of a patient's health and have identified the clinical need for a medicine before prescribing. See the summary flowchart for managing requests for CDs in Appendix A (1b).

7.9.1 Do's

Clinical Screen Does the patient:	
Flags	1. Have any record e.g. special patient note (SPN) on the computer aided dispatch (CAD) for frequent requests or evidence of using multiple services for CDs i.e. ≥8 calls/1 month? Follow patient specific instruction if available, do not supply the CD, complete a Datix report and inform the patient's GP. 2. Have signs of DSB?

	Do not supply the CD, complete a Datix report and inform the patient's GP who will then discuss the identified risk with the patient and add this information/patient risk to the NCRS/SCR under past medical history (PMH). The safeguarding team and CDAO may be informed if escalation is required.
Medical History	3. Have sufficient clinical history to support their presentation? Assess via national care records service e.g. KMCR, SyCR, NCRS, including diagnosis, contra-indications, prior supply of the CD (acute or repeat prescription) and/or alerts such as SPNs Patients or their healthcare professional e.g. paramedic or palliative care nurse requesting CDs for palliative or end of life care should be prioritised and urgently referred to a clinician for the management of new or worsening symptoms or anticipatory medicines.
Consultation Steps	
Identification (ID)	1. Explain that as CDs are being requested further identify checks will be required such as photographic identification. Carry these out directly with the patient (excepting young children/LD patients) 2. Request three additional identifiers from the ePCR (e.g. previous medication, previous treatment, surgery details) 3. Where possible a video consultation should be arranged for a CD request
Urgency	4. Establish if there is an immediate and urgent clinical need which cannot be reasonably serviced by primary care? Consider e.g. closure of their GP surgery or whether the CD is still needed (e.g. post-surgery). 5. Prioritise end of life/palliative care requests.
Consent to share	6. Obtain consent to sharing clinical information with their GP (explain to the patient that this is required for optimal treatment planning and their safety). 7. If consent is refused then the CD prescription is not possible as there is no safety netting/follow up for the patient
Holistic management	8. Advise alternative interventions* where appropriate (e.g. pain or musculoskeletal clinics, mental health services, supervised group exercise programme).
Review co-morbidities	9. Review medication regime/PMH: Is the patient currently taking any other medication or are there patient-specific factors that would adversely affect the CD in question? (e.g. contra-indications, over the counter (OTC) medicines, history of alcohol/illicit drug misuse, opioid naivety, interactions)
Confirm CD details	10. Confirm: ○ Any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. ○ Clarify the following: a. Indication, onset time(s) and duration.

	b. How to take any modified (MR) or immediate release formulations (as per MHRA warning do not prescribe MR opioids post- surgery) c. How to take 'when required' doses and maximum total doses d. Standard dosing increments (if any)
Limit quantity prescribed	11. Prescribe a **limited quantity** of generically written (non-branded) CDs – **3 days is a recommended maximum until primary care access is possible** (the only exception to this is over a bank holiday when 5 days may be required before primary care access is possible). 12. Ensure the legal prescription requirements for CDs are met (see appendix D).
Adverse Drug Reactions (ADRs)	13. Inform the patient of potential side effects and risk of dependence 14. Remind the patient of warnings, including not to drive if affected with drowsiness
Summary	15. Summarise for the patient: ○ The CD is **for their use only**. ○ They may be required to **show their ID** when collecting their medication at the pharmacy. ○ It is good practice for prescribers to contact the community pharmacy when sending a controlled drug prescription to ensure that the pharmacist will check the patient's identification/are familiar with the patient and that they have supplies of the medication. If the community pharmacist requires further information, they may contact the healthcare practitioner (HCP) line via NHS 111 ○ Signpost - Refer the patient to health resources for further management of their symptoms (e.g. NHS choices, MedlinePlus (health information in multiple languages), and see Appendix E. ○ Take any unused medication to a community pharmacy for disposal.
Post-consultation	
Record	1. Ensure consultation and all prescribing decisions are clearly documented in consultation notes/ Record all outcomes in Post Event Message e.g. PaCCs
Communicate with GP	2. Notify the patient's GP of all prescribing decisions, stating rationale for any medicine prescribed, including quantity and dose prescribed with any monitoring requirements – also documented in consultation notes
Yellow Card if ADRs	3. Report any adverse drug reactions using the Yellow Card scheme (if the patient is not already doing so)
Communicate with clinical services lead (CSL)	4. Report suspected DSB to CAS clinical navigator (CCN) and via datix report (as information escalation may be required to partner organisations via the CDAO)

	5. Refer suspected DSB to the patient's GP to ensure updated patient care record/identified risk to safeguard future interactions with the service and patient safety

* Management options in the NICE guideline for the condition (for example, NICE guidelines on endometriosis, headaches, irritable bowel syndrome, low back pain and sciatica, neuropathic pain, osteoarthritis, rheumatoid arthritis, spondyloarthritis)

7.9.2 Don'ts

Do NOT prescribe CDs in the scenarios listed below using your clinical judgement and see appendix A 1b for a decision aid.

Avoid prescribing where:	
Illegal or outside of practice scope	1. You cannot legally do so (see Appendix C) 2. The clinical scenario is outside of your competency (or scope of practice for non-medical prescribers)
No ID	3. The patient has not passed their identity checks (photographic ID is essential e.g. passport, driving license, etc., as this may also be required when collecting the prescription from the community pharmacy). Video consultation is recommended for CD requests where possible
Non-UK and/or no NHS number	4. The patient's home address is based overseas (this is a legally complex issue). 5. Without an NHS number, SECAmb cannot prescribe. 6. Refer these patients to local services such as emergency departments and urgent treatment centres for a prescription. 7. For UK patients outside of England these requests will need to be referred to their home nations/healthcare providers
No health record access	5. There is no access to the patient's health record, or the health record is inadequate to assure a clear clinical history of previous CD prescribing/clinical indication for safe prescribing of CDs
Non-consent	6. The patient has refused consent to communicate any CD prescription details to their GP
Coercion	7. The patient is under duress to request a prescription (consider a safeguarding referral) or is attempting to coerce a CD prescription/is aggressive in approach. A datix is required in this scenario and CCN contacted for support.
CD for addiction management or installments	8. The medication being requested is a schedule 1 CD or a CD prescribed for the treatment of addiction (e.g buprenorphine or methadone) supervised consumption, or supplied via instalment prescribing such as 7 day prescriptions
Diversion risk	9. Do not prescribe where it is not in the patient's best interest (including a high risk of diversion): a. Claims to have lost their CD or that they have just moved into the area.

	b. Expresses extraordinary knowledge of CDs +/- resisting other therapeutic options. c. Claims multiple allergies to non-opioids. d. Has a history of substance misuse. e. Expresses inconsistent symptoms. f. Is aggressively asking for a CD or making threats. (Do NOT supply) 10. Medical records showing: a. Frequent user of OOH/CAS services (≥8 calls/1 month) or use of multiple agencies to obtain prescriptions including the internet. (Check care record e.g. NCRS, KMCR) Do NOT supply. b. Reluctance to answer questions about presenting complaints or medical history. Do NOT supply. c. Taking more than the prescribed dose/requesting a repeat to early. Do NOT supply. 11. Apply clinical judgement: a. Multiple allergies e.g. to non-opioid analgesics. b. Taking medication prescribed for someone else. c. More than 3 months use of the CD, particularly at high doses. d. Not had a medication review in over 12 months.
Examination required	12. Safe prescribing would require you to physically examine the patient and this is not possible remotely- signpost to next available GP appointment.

7.9.3 If a decision is taken not to prescribe

In the event that the prescriber decides that the issue of a CD prescription is not in the patient's best interest, the following responses are recommended:

1. Explain your reasons to the patient and explore other options that might be available to the patient.
2. Provide or direct the patient to health resources for managing their condition e.g. NHS choices and/or next available GP appointment.
3. Provide the patient with worsening care advice.
4. Notify patient's GP of your prescribing decision.
5. Clearly document your reasons for not prescribing in the consultation notes.
6. Complete a Datix report to ensure the Trust and local stakeholders have oversight of the case and to support risk management.

8 Monitoring compliance

8.1 The Medicines Governance Group is responsible for monitoring compliance with this document.

8.2 The Medicines Team will provide prescribing data on CDs to the MGG and local stakeholders (e.g. ICB commissioners).

8.3 Audits on CD prescribing and a quarterly prescribing report will be undertaken in 111 to identify trends in the prescribing of CDs. Datix reports relating to DSB will also be brought to MGG and CDAO if escalation is required.

8.4 Any concerns will be discussed with the operations manager and individual prescribers.

9 Audit and Review (evaluating effectiveness)

9.1 Effectiveness of this procedure will be audited by the Medicines Governance Group at regular intervals, and initially six months after a new procedure is approved and disseminated.

9.2 Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

9.3 This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the procedure is not working effectively.

9.4 All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

10 Financial Checkpoint

12.1 To ensure that any financial implications of changes in policy or procedure are considered in advance of document approval, document authors are required to seek approval from the Finance Team before submitting their document for final approval.

12.2 This document has been confirmed by Finance to have no unbudgeted financial implications.

11 Equality Analysis

13.1 The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and

exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

13.2 Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

Appendix A

1. Flowchart 1a: Processing repeat prescription requests for CDs to 111 call handlers/healthcare assistants

Caller requests medication(s)

Patient is asked to spell medication(s) and/or request is copied and pasted into CAS

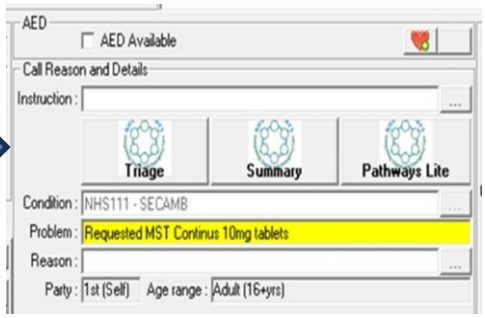
Product name and strength is searched in the dm+d browser or in the alphabetical list from the Home Office: List of most commonly encountered drugs currently controlled under the misuse of drugs legislation - GOV.UK to determine **if a controlled drug (CD) has been requested?**

Are any of the medication(s) a controlled drug (CD) in **schedules 2 to 5?**

Yes

No

Copy and paste **CD name** to patient case/call page so it is visible in the stack



Refer **CD request** to CAS prescribers

Prescribers refer to the decision aid in flowchart 1b

Refer to directory of services (DOS) for available local community pharmacy for Pharmacy First urgent repeat prescriptions

Appendix A

2. Flowchart 1b: Decision aid for prescribers

Patient requests a Controlled Drug (CD) Medication

1. Is CD request from the stack one to prioritise? e.g. if EOL request decide to intervene early
2. Can you legally prescribe the medication requested? See appendix C
3. Check SCR/GP Connect/KMCR/SyCR: Is the CD requested used for addiction treatment or does the patient require weekly or post-dated scripts?

Do not prescribe: explain reasoning, offer self-care advice and refer to usual services e.g. drug team/primary care

4. Does the patient have any flags on CAD for frequent requests (≥8 calls /month) or using multiple services to obtain CDs (>twice in 30 days)?

Do not prescribe: Follow patient specific instruction if available or inform patient's GP to schedule a patient review and Datix report drug seeking behaviour for review by the Trust

111 Consultation

5. Do you have sufficient clinical history from care records to support patient identification and acute presentation OR request for repeat medication?
6. Does the patient have an NHS number and are they registered with a GP?
7. Does the patient have capacity, agree to further ID checks and sharing information with their GP? Use video conferencing to check photographic ID with the patient and confirm details from their SCR with them- record this in CAD
8. Is the patient at risk of diversion (see table 8) or aggressively seeking CDs?

Do NOT prescribe

9. Does the patient have an immediate clinical need that cannot reasonably be serviced by primary care within working hours?
10. Are there any contra-indications or medication interactions that may affect the CD requested?

Shared decision to prescribe

11. Discuss features of tolerance, dependence (>3/12 use) and addiction and agree a follow up plan
12. Supply shortest possible quantity until next available GP appointment- SECAmb recommendation is 3 days MAXIMUM (5 days may be necessary if covering a bank holiday) in line with emergency supply regulations
13. Record all outcomes in Pathways Clinical Consultation System (PaCCS)
14. Inform the patient that on collection from the community pharmacy they may be asked for photographic identification

Appendix B: Medicines associated with dependency

These medicines have a controlled drug schedule when searching on dm+d.

A **Benzodiazepines (BDZ):** Are mainly used to treat insomnia, anxiety, epilepsy and as muscle relaxants (e.g. diazepam schedule 4 CD, temazepam schedule 3 CD). To avoid dependence and tolerance, BDZ are only recommended for short term use (e.g. 2–4 weeks for the treatment of severe anxiety or insomnia)

B **Z-drugs:** Are hypnotics similar to BDZ but have a different chemical structure (.e..g. zopiclone and zolpidem). They are used for treating severe insomnia in short term (for up to 4 weeks). These medicines are schedule 4 CDs.

C **Gabapentinoids:** Are used to treat epilepsy and neuropathic pain (e.g. gabapentin and pregabalin). Pregabalin is also licensed for the treatment of anxiety. Both drugs were re-classified in 2019 as schedule 3 controlled drugs (CDs) due to the risk of abuse and dependence.

D **Opioids:** Are mainly used for their analgesic effect (e.g. codeine, morphine and tramadol) in moderate to severe pain. Codeine is CD schedule 5, morphine tablets CD schedule 2 and tramadol CD schedule 3. They can be effective for somatic pain but are only recommended for short to medium-term treatment of chronic non-malignant pain - when other therapies have proven insufficient, and the opioid benefits outweigh the risks of harm. Patients with chronic non-malignant pain, should be encouraged to utilise non-pharmacological interventions such as stimulating techniques (TENS machine), acupuncture, physiotherapy, increasing physical fitness, psychological therapies and meditation techniques.

Examples of CDs and their scheduling requirements according to the Misuse of Drugs Regulations (MDR):

CD Schedule	**2**	**3**	**4**	**5**
Examples	Diamorphine Fentanyl Methadone* Morphine Oxycodone	Buprenorphine* Gabapentin Pregabalin Temazepam Tramadol	Diazepam Lorazepam Zolpidem Zopiclone	Codeine Dihydrocodeine Co-codamol 30/500

*These medicines are often prescribed in instalments for the management of addiction and for this indication will not be prescribed from 111.

Appendix C: Controlled Drug Prescribing by Role

Prescribing authorisation

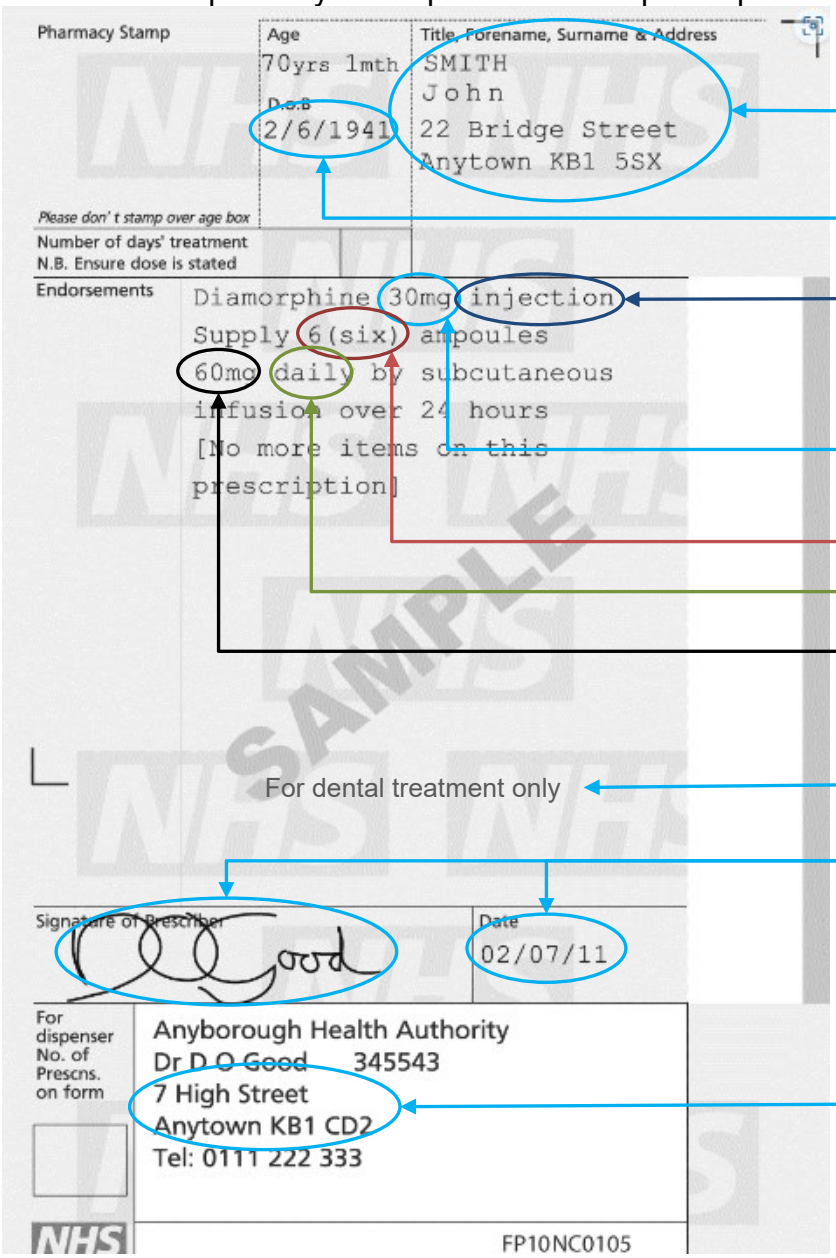
The registrants listed below may prescribe the following CDs, once they are deemed competent and authorised by SECAmb to do so. Non-medical prescribers will work within their own level of competence and expertise and within their scope of practice.

Profession	CDs legally allowed to prescribe	Route of admin.
Doctor	Any CDs in schedules 2-5 of the Misuse of Drugs Regulations (MDR) apart from medicines when used for the treatment of addiction and cannabis.	Any
Nurse	Any CDs in schedules 2-5 of the MDR apart from medicines when used for the treatment of addiction, and cannabis.	Any
Pharmacist	Any CDs in schedules 2-5 of the MDR apart from medicines when used for the treatment of addiction, and cannabis.	Any
Paramedic[1]	Morphine sulphate	Oral or injection
	Diazepam	Oral or injection
	Midazolam	Oromucosal or injection
	Lorazepam	Injection
	Codeine phosphate	Oral

[1] Legislation changes in The Misuse of Drugs (England and Wales and Scotland) (Amendment) (No. 2) Regulations 2023 came into force on the 31st December 2023 - you can read the full changes here.

Appendix D: Legal requirements for Controlled Drugs

Note: A pharmacist is **not** allowed to dispense a Controlled Drug unless all the information required by law is present on the prescription.



[0] If the patient does not have a fixed address (e.g. because they're homeless or under a witness protection scheme), 'no fixed abode' or 'NFA' is acceptable. Use of a PO Box is not acceptable.

[1] to avoid ambiguity, where a prescription requests multiple strengths of a medicine, each strength should be prescribed separately (i.e. separate dose, total quantity, etc).

[2] for liquids, the total volume in millilitres of the preparation to be supplied; for dosage units (tablets, capsules, ampoules), state the total number of dosage units to be supplied (e.g. 10 tablets [of 10 mg] rather than 100 mg total quantity).

[3] the instruction 'one as directed' constitutes a dose, but 'as directed' does notes.

[4] e.g. Take 1 tablet as directed is legally permissible, but thought should be given as to whether this is in the patient's best interest.

Appendix E: Patient information and leaflets (PIL)

a) A-Z of health - NHS patient information for their condition:
b) Anxiety and insomnia PIL
c) Children's Medicines
d) Mental Health medicines easy read/Learning Disability
e) Sleep - A good sleep guide
f) Foreign Language PILs (generally not for older medication):

i. Search for the drug in question.

ii. Click on the link to the EPAR in the search results (if available).

iii. Click on 'Product Information'.

iv. Click on 'Available languages' and chose the language you require.

v. The PIL will usually be the last section of the downloaded pdf.