Hot topics for NMPs
Professional and clinical update

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West Suffolk Integrated Pain Management Service

SGPF Governance Team
October 21st 2019

Meeting supported by Suffolk and North East Essex Primary Care Training Hub

Suffolk GP FEDERATION

West Suffolk NHS
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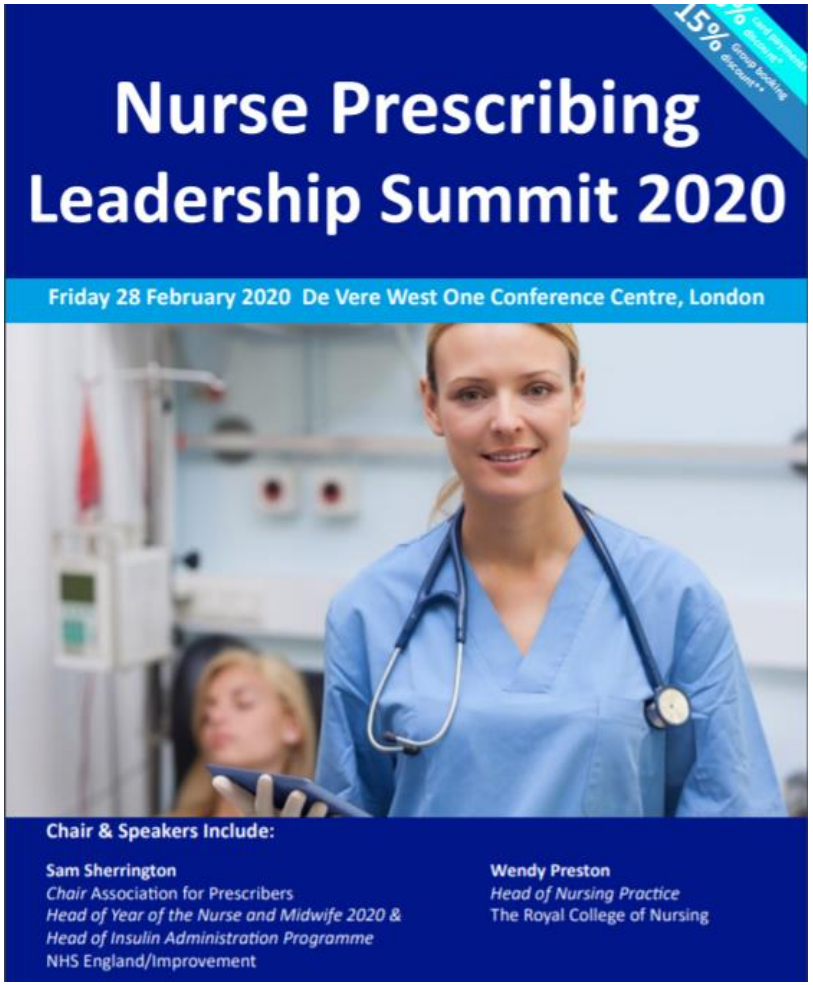
Professional update for NMPs

NMP Leadership summit 2020



Competency Framework for Designated Prescribing Practitioners: consultation


Bournemouth University

Faculty of Health and Social Sciences

Practice Assessor/Practice Supervisor Handbook

Independent and Supplementary Prescribing / Supplementary Prescribing

September 2019

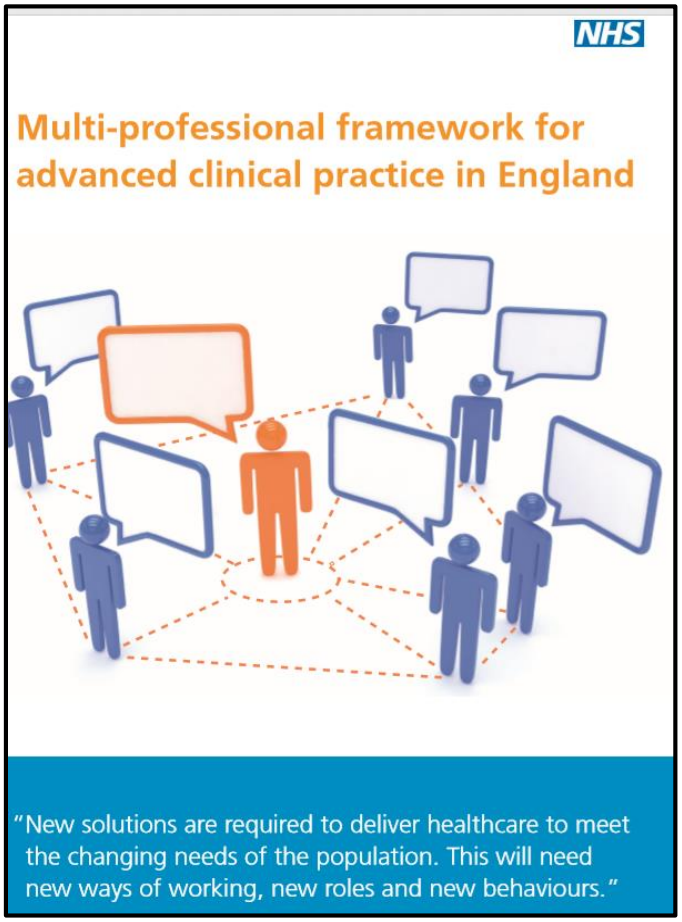

Competency Framework for Designated Prescribing Practitioners: Consultation Questions

The consultation questions below relate to the Competency Framework for Designated Prescribing Practitioners. The consultation document can be accessed here https://www.rpharms.com/recognition/all-our-campaigns/competency-framework-for-designated-prescribing-practitioners. This consultation will remain open from Friday 21st June 2019 to Friday 2nd August 2019.

This consultation is closed

Estimated publication date: **December 2019**

Advanced Clinical Practice



Further information

- Designated ACP Lead/Professional Development Lead

  Primary Care
- See SNEE training manual under ACP for more information and then contact the University you wish to study at for course specific requirements / how to proceed.

Resources

- HEE ACP website
  https://www.hee.nhs.uk/our-work/advanced-clinical-practice
- ACP multi-professional framework
  https://www.lasepharmacy.hee.nhs.uk/dyn/_assets/_folder4/advanced-practice/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

Advanced Clinical Practice (ACP):
ACP apprenticeships, top ups or stand alone modules

ACP apprenticeship	Top up to full ACP
HEE Funding The apprenticeship ACP full programme is being supported by increasing education capacity and is the main model option for funding for 2020/2021 ACP programmes commissioned by HEE must meet the 4 pillars outlined in the HEE Multi–Professional Framework	**HEE Funding** Partial funding for top up available ACP programmes commissioned by HEE must meet the 4 pillars outlined in the HEE Multi –Professional Framework
How many credits funded by HEE? 180 credits	**How many credits funded by HEE?** Following HEE funding assessment of learner by the education provider, funding for tuition available for up to 100 credits (out of 180 credits). If further modules required learner will have to pay additional modules
Who is this pathway suited for? Ideal for learners without a PgCert/ diploma who wishes to obtain ACP qualification	**Who is this pathway suited for?** Ideal for HCPs who have completed a ACP programme to PgCert/ diploma and who wishes to top up to full ACP master
How many places are being commissioned in EoE? 2019/2020: 217 places	**How many places are being commissioned in EoE?** 2019/2020: 106 places

Stand alone masters

HEE will not offer stand alone master modules as these will not meet the aspirations of the ACP framework and proposed career pathway

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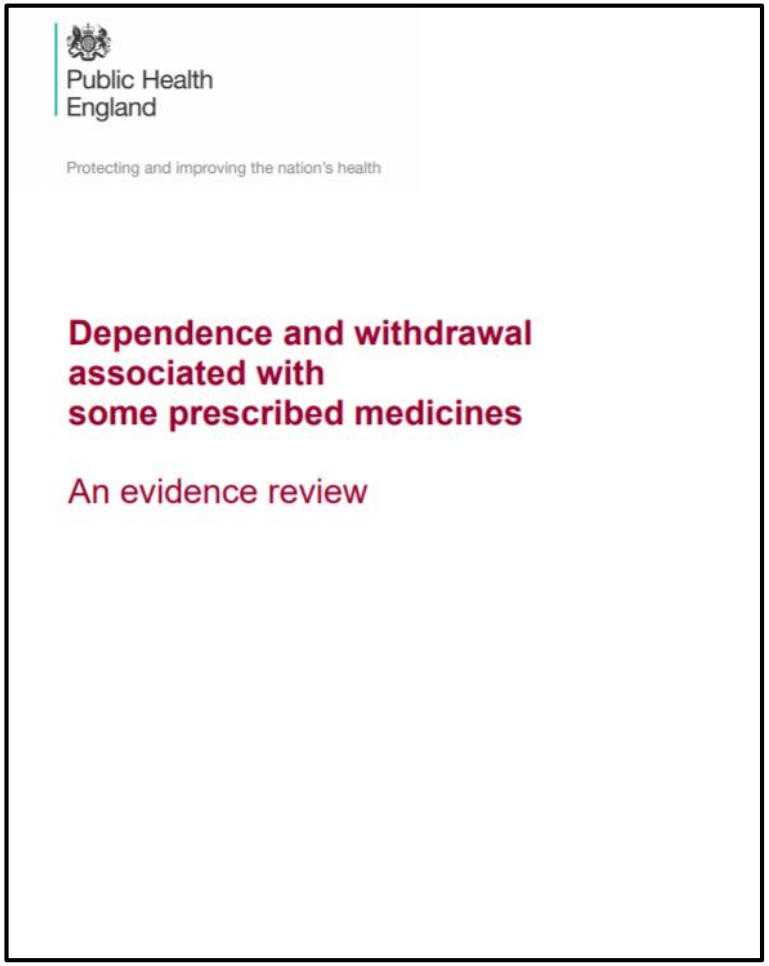
Clinical update for NMPs

Who do you see?

- Antidepressants
- Z-drugs
- Benzodiazepines
- Gabapentinoids
- Opioids
- Prescription drug seeking behaviours
- Substance misuse

PHE Review of dependency forming medications (DFMs) (1)

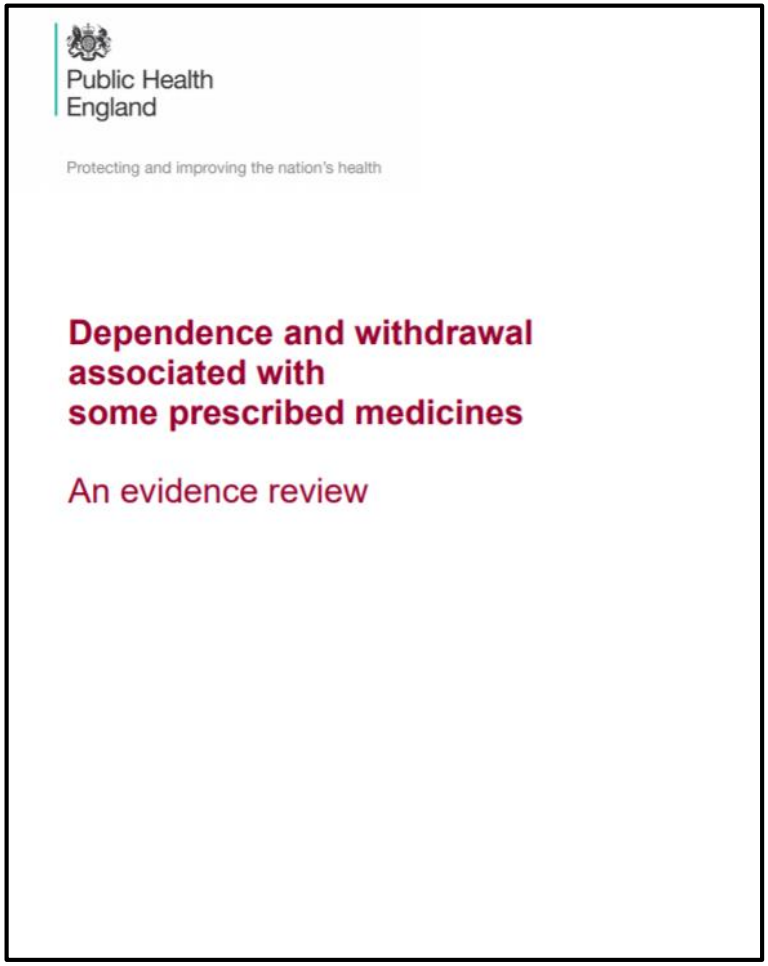


Review Included:

- Benzodiazepines
- Z-drugs
- Gabapentinoids
- Opioids
- Antidepressants

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/829777/PHE_PMR_report.pdf

PHE Review of DFMs(2)



Findings

- 1 in 4 adults had been prescribed at least one of these classes of medicines in the year ending March 2018
- In March 2018 half of those receiving a prescription (of these classes of medicine) had been continuously prescribed for at least the previous 12 months
- Between 22% and 32% of patients (depending on the medicine class) had received a prescription for at least the previous 3 years

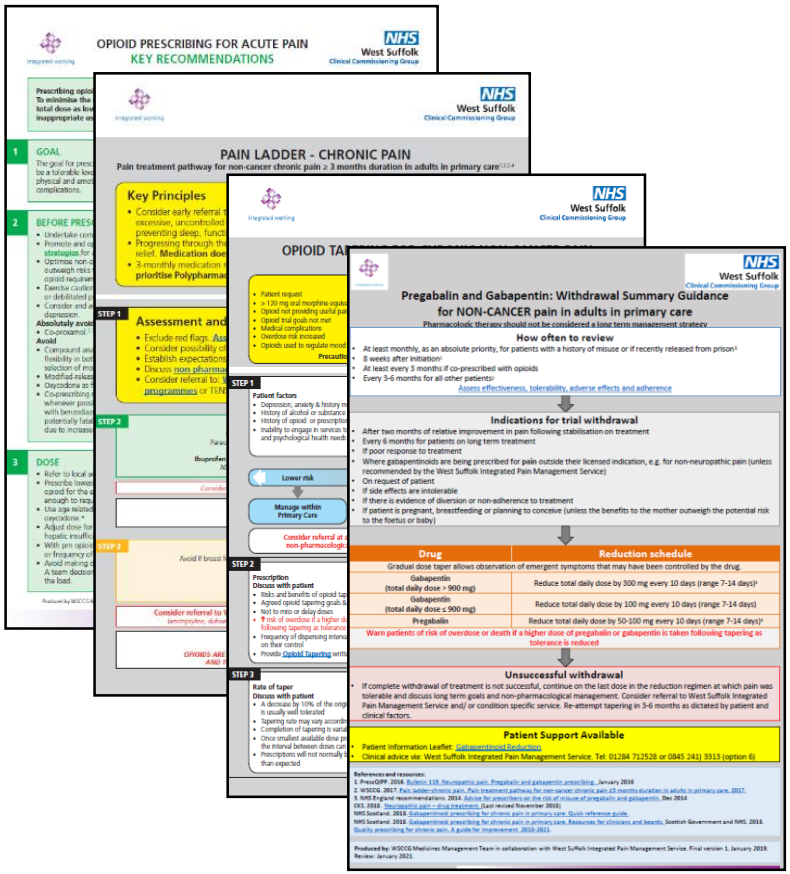
PHE Review of DFMs (3)

Recommendations

PHE's recommendations fall into 5 broad categories which are:

1. Increasing the availability and use of data on the prescribing of medicines that can cause dependence or withdrawal to support greater transparency and accountability and help ensure practice is consistent and in line with guidance.
2. Enhancing clinical guidance and the likelihood it will be followed.
3. Improving information for patients and carers on prescribed medicines and other treatments, and increasing informed choice and shared decision making between clinicians and patients.
4. Improving the support available from the healthcare system for patients experiencing dependence on, or withdrawal from, prescribed medicines.
5. Further research on the prevention and treatment of dependence on, and withdrawal from, prescribed medicines.

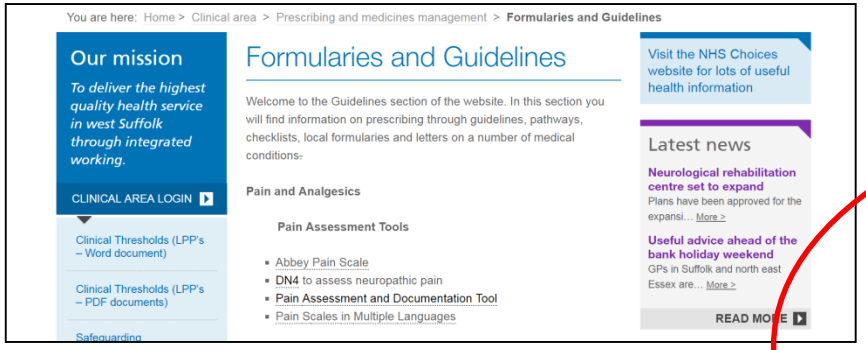
DFMs: Guidance training



Prescribing and deprescribing guidance

- Opioids Aware
- Evidence base
- Risk versus benefits/safety
- Recognising the high risk patient
- *Clinical guidance*
  - Non-pharmacological approaches /resources
  - Reducing risks with opioid and gabapentinoid prescribing
  - Deprescribing guidance
- Resources for HCPs

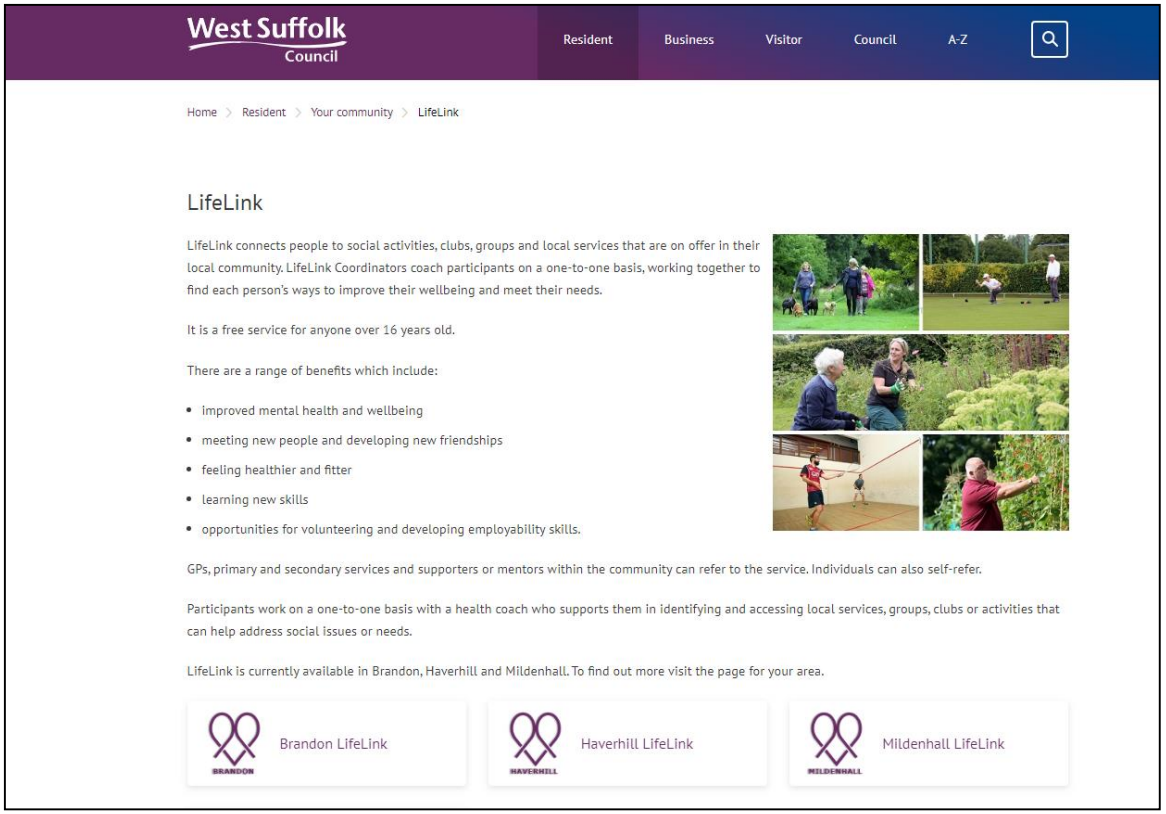
DFMs: Patient information on WSCCG wesbite



Pain and analgesics

- Pain assessment tools
- Prescribing guidance
- Deprescribing guidance
- Patient information (medications)
- Non-pharmacological resources and leaflets to support self management
- National guidance/key resources

DFMs: Social prescribing

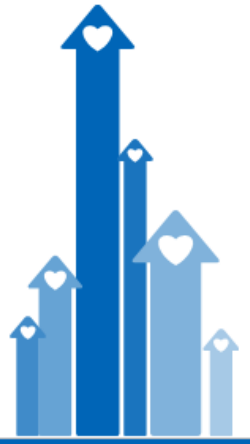


https://www.westsuffolk.gov.uk/community/lifelink/index.cfm

DFMs: Out of Hours Service

Common reasons for requests from OOH

1. Lost or stolen prescription or medication
2. GP not issued medication
3. Unable to make an appointment with a GP/ for a review
4. Pharmacy closed
5. Discharged from the hospital without medication
6. Patches keep falling off
7. Patient does not have a GP

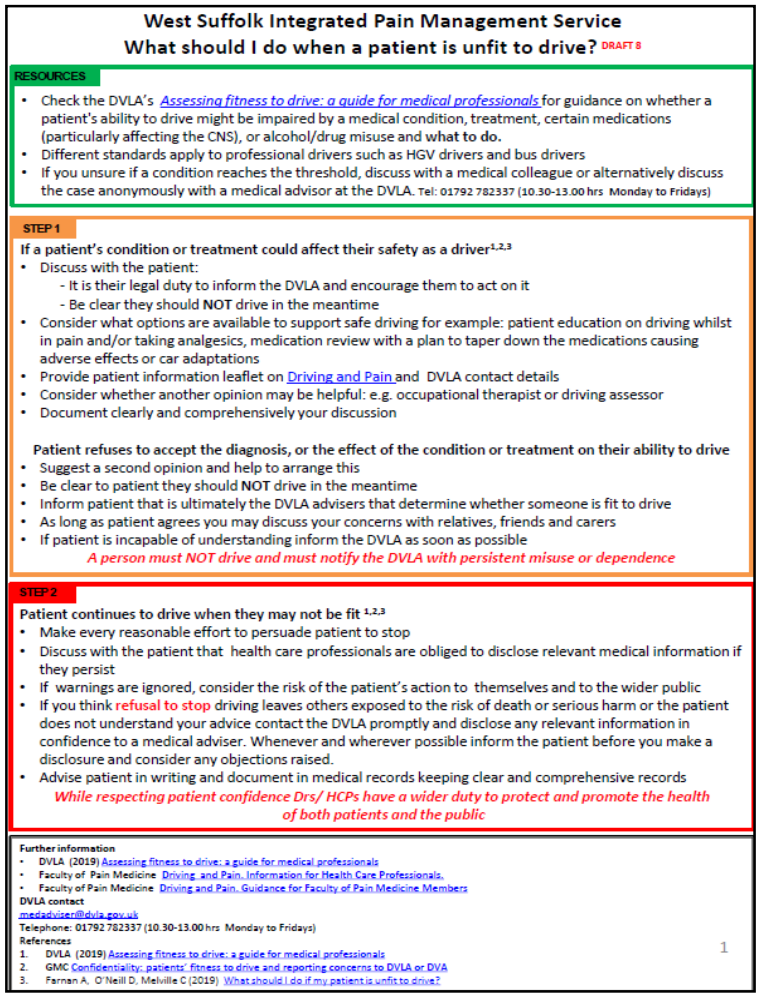


DFMs: Out of Hours Service

How are we tackling the problem

1. Shared learning
2. Special patient notes
3. Direct communication with patients' own GPs
4. Direct feedback to prescribers
5. Thorough audits
6. Reduced quantities prescribed
7. Making it more difficult for patients to obtain their medication
8. Creating a working group to prepare a local guideline for all OOH providers which would allow unified approach to patients using the service to obtain drugs of misuse
9. Involving local CCGs
10. Creating a contract for clinicians to sign regarding the prescribing of drugs of misuse

Guidance for driving



West Suffolk Integrated Pain Management Service
What should I do when a patient is unfit to drive? DRAFT 8

RESOURCES

- Check the DVLA's *Assessing fitness to drive: a guide for medical professionals* for guidance on whether a patient's ability to drive might be impaired by a medical condition, treatment, certain medications (particularly affecting the CNS), or alcohol/drug misuse and **what to do.**
- Different standards apply to professional drivers such as HGV drivers and bus drivers
- If you unsure if a condition reaches the threshold, discuss with a medical colleague or alternatively discuss the case anonymously with a medical advisor at the DVLA. Tel: 01792 782337 (10.30-13.00 hrs Monday to Fridays)

STEP 1

If a patient's condition or treatment could affect their safety as a driver[1,2,3]

- Discuss with the patient:
  - It is their legal duty to inform the DVLA and encourage them to act on it
  - Be clear they should **NOT** drive in the meantime
- Consider what options are available to support safe driving for example: patient education on driving whilst in pain and/or taking analgesics, medication review with a plan to taper down the medications causing adverse effects or car adaptations
- Provide patient information leaflet on Driving and Pain and DVLA contact details
- Consider whether another opinion may be helpful: e.g. occupational therapist or driving assessor
- Document clearly and comprehensively your discussion

Patient refuses to accept the diagnosis, or the effect of the condition or treatment on their ability to drive

- Suggest a second opinion and help to arrange this
- Be clear to patient they should **NOT** drive in the meantime
- Inform patient that is ultimately the DVLA advisers that determine whether someone is fit to drive
- As long as patient agrees you may discuss your concerns with relatives, friends and carers
- If patient is incapable of understanding inform the DVLA as soon as possible

A person must NOT drive and must notify the DVLA with persistent misuse or dependence

STEP 2

Patient continues to drive when they may not be fit [1,2,3]

- Make every reasonable effort to persuade patient to stop
- Discuss with the patient that health care professionals are obliged to disclose relevant medical information if they persist
- If warnings are ignored, consider the risk of the patient's action to themselves and to the wider public
- If you think refusal to stop driving leaves others exposed to the risk of death or serious harm or the patient does not understand your advice contact the DVLA promptly and disclose any relevant information in confidence to a medical adviser. Whenever and wherever possible inform the patient before you make a disclosure and consider any objections raised.
- Advise patient in writing and document in medical records keeping clear and comprehensive records

While respecting patient confidence Drs/ HCPs have a wider duty to protect and promote the health of both patients and the public

Further information

- DVLA (2019) Assessing fitness to drive: a guide for medical professionals
- Faculty of Pain Medicine Driving and Pain. Information for Health Care Professionals.
- Faculty of Pain Medicine Driving and Pain. Guidance for Faculty of Pain Medicine Members

DVLA contact

medadviser@dvla.gov.uk
Telephone: 01792 782337 (10.30-13.00 hrs Monday to Fridays)

References

1. DVLA (2019) Assessing fitness to drive: a guide for medical professionals
2. GMC Confidentiality: patients' fitness to drive and reporting concerns to DVLA or DVA
3. Farnan A, O'Neill D, Melville C (2019) What should I do if my patient is unfit to drive?

1

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Driving and Pain

Information for Patients

Am I able to drive whilst taking medications prescribed for pain?

Yes, but only if your ability to drive is not impaired. Medications prescribed to help manage pain may cause side-effects such as dizziness or sleepiness and so may impair your driving.

It remains the responsibility of all drivers to decide whether they consider their driving is, or might be impaired on any given occasion. Do not drive if this is the case. Sometimes your doctor may advise you not to drive. If this is the case, even if you do not feel impaired, you must not drive as it is against the law to do so.

What symptoms may mean I cannot drive safely?

Do not drive if you experience symptoms that may impair your driving such as sleepiness, poor coordination, impaired or slow thinking, dizziness or visual problems. These symptoms can occur as side effects of medication, but be aware that pain itself can also affect sleep, concentration and impair physical function.

When might I be at risk of my driving being impaired?

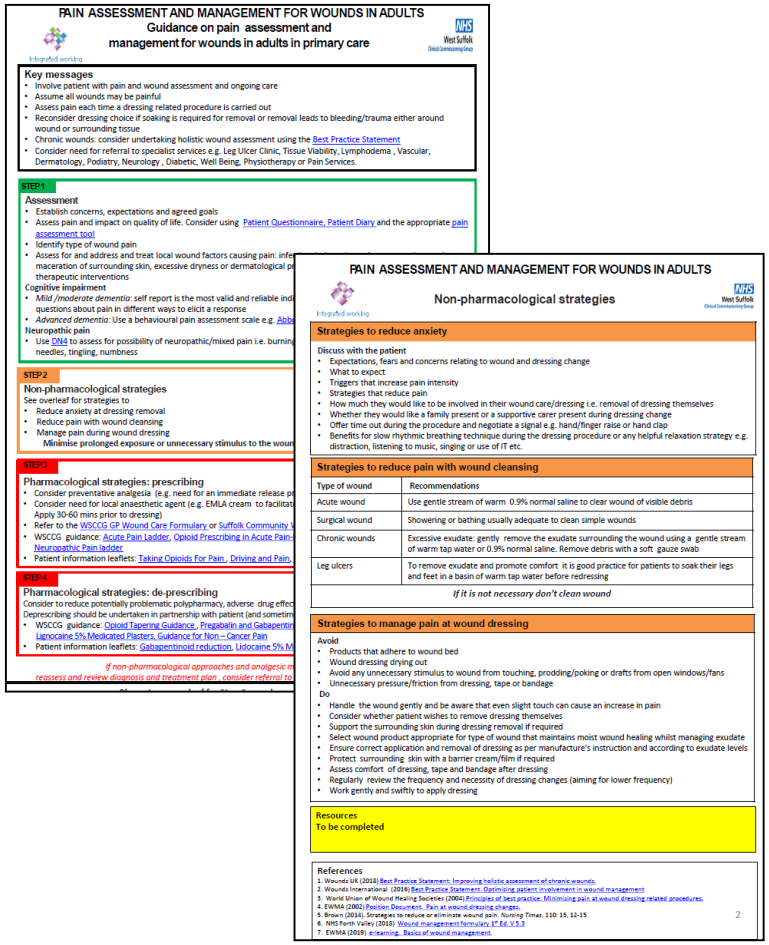
This includes the following circumstances that may increase the risk of your driving being impaired:

- When first starting a new pain medication
- When increasing or reducing the dose of pain medication
- If another prescribed medication is added that could also impair your driving
- If you take an over the counter medicine that could also impair your driving
- If you have a pain condition that could physically impair your driving

Be aware that alcohol taken in combination with some pain medications can substantially increase the risk of accidents.

1.

Pain assessment and management for wounds



PAIN ASSESSMENT AND MANAGEMENT FOR WOUNDS IN ADULTS

Guidance on pain assessment and management for wounds in adults in primary care

Integrated working

NHS West Suffolk Clinical Commissioning Group

Key messages

- Involve patient with pain and wound assessment and ongoing care
- Assume all wounds may be painful
- Assess pain each time a dressing related procedure is carried out
- Reconsider dressing choice if soaking is required for removal or removal leads to bleeding/trauma either around wound or surrounding tissue
- Chronic wounds: consider undertaking holistic wound assessment using the Best Practice Statement
- Consider need for referral to specialist services e.g. Leg Ulcer Clinic, Tissue Viability, Lymphodema , Vascular, Dermatology, Podiatry, Neurology , Diabetic, Well Being, Physiotherapy or Pain Services.

STEP1

Assessment

- Establish concerns, expectations and agreed goals
- Assess pain and impact on quality of life. Consider using Patient Questionnaire, Patient Diary and the appropriate pain assessment tool
- Identify type of wound pain
- Assess for and address and treat local wound factors causing pain: infe… maceration of surrounding skin, excessive dryness or dermatological p… therapeutic interventions

Cognitive impairment

- *Mild /moderate dementia*: self report is the most valid and reliable indi… questions about pain in different ways to elicit a response
- *Advanced dementia*: Use a behavioural pain assessment scale e.g. Abb…

Neuropathic pain

- Use DN4 to assess for possibility of neuropathic/mixed pain i.e. burning… needles, tingling, numbness

STEP2

Non-pharmacological strategies

See overleaf for strategies to

- Reduce anxiety at dressing removal
- Reduce pain with wound cleansing
- Manage pain during wound dressing
  Minimise prolonged exposure or unnecessary stimulus to the woun…

STEP3

Pharmacological strategies: prescribing

- Consider preventative analgesia (e.g. need for an immediate release p…
- Consider need for local anaesthetic agent (e.g. EMLA cream to facilitat… Apply 30-60 mins prior to dressing)
- Refer to the WSCCG GP Wound Care Formulary or Suffolk Community …
- WSCCG guidance: Acute Pain Ladder, Opioid Prescribing in Acute Pain; Neuropathic Pain ladder
- Patient information leaflets: Taking Opioids For Pain , Driving and Pain,

STEP4

Pharmacological strategies: de-prescribing

Consider to reduce potentially problematic polypharmacy, adverse drug effec…

Deprescribing should be undertaken in partnership with patient (and sometim…

- WSCCG guidance: Opioid Tapering Guidance , Pregabalin and Gabapentin… Lignocaine 5% Medicated Plasters. Guidance for Non – Cancer Pain
- Patient information leaflets: Gabapentinoid reduction, Lidocaine 5% M…

If non-pharmacological approaches and analgesic m… reassess and review diagnosis and treatment plan , consider referral to…

PAIN ASSESSMENT AND MANAGEMENT FOR WOUNDS IN ADULTS

Non-pharmacological strategies

Integrated working

NHS West Suffolk Clinical Commissioning Group

Strategies to reduce anxiety

Discuss with the patient

- Expectations, fears and concerns relating to wound and dressing change
- What to expect
- Triggers that increase pain intensity
- Strategies that reduce pain
- How much they would like to be involved in their wound care/dressing i.e. removal of dressing themselves
- Whether they would like a family present or a supportive carer present during dressing change
- Offer time out during the procedure and negotiate a signal e.g. hand/finger raise or hand clap
- Benefits for slow rhythmic breathing technique during the dressing procedure or any helpful relaxation strategy e.g. distraction, listening to music, singing or use of IT etc.

Strategies to reduce pain with wound cleansing

Type of wound	Recommendations
Acute wound	Use gentle stream of warm 0.9% normal saline to clear wound of visible debris
Surgical wound	Showering or bathing usually adequate to clean simple wounds
Chronic wounds	Excessive exudate: gently remove the exudate surrounding the wound using a gentle stream of warm tap water or 0.9% normal saline. Remove debris with a soft gauze swab
Leg ulcers	To remove exudate and promote comfort it is good practice for patients to soak their legs and feet in a basin of warm tap water before redressing

If it is not necessary don't clean wound

Strategies to manage pain at wound dressing

Avoid

- Products that adhere to wound bed
- Wound dressing drying out
- Avoid any unnecessary stimulus to wound from touching, prodding/poking or drafts from open windows/fans
- Unnecessary pressure/friction from dressing, tape or bandage

Do

- Handle the wound gently and be aware that even slight touch can cause an increase in pain
- Consider whether patient wishes to remove dressing themselves
- Support the surrounding skin during dressing removal if required
- Select wound product appropriate for type of wound that maintains moist wound healing whilst managing exudate
- Ensure correct application and removal of dressing as per manufacture's instruction and according to exudate levels
- Protect surrounding skin with a barrier cream/film if required
- Assess comfort of dressing, tape and bandage after dressing
- Regularly review the frequency and necessity of dressing changes (aiming for lower frequency)
- Work gently and swiftly to apply dressing

Resources
To be completed

References

1. Wounds UK (2018) Best Practice Statement: Improving holistic assessment of chronic wounds.
2. Wounds International (2016) Best Practice Statement. Optimising patient involvement in wound management
3. World Union of Wound Healing Societies (2004) Principles of best practice. Minimising pain at wound dressing related procedures.
4. EWMA (2002) Position Document. Pain at wound dressing changes.
5. Brown (2014). Strategies to reduce or eliminate wound pain. Nursing Times. 110: 15, 12-15.
6. NHS Forth Valley (2018) Wound management formulary 3rd Ed. V 5.3
7. EWMA (2019) e-learning. Basics of wound management.

2

e-learning

Pain champions

Face to face

- WSCCG Practice Nurse Forum Primary Care: Leg ulcer 2 day study day
- Primary Care: Principles of wound management
- Principles of pain management for primary care
- Pain management for complex wounds

IPMS referrals and leaflets

Suffolk GP FEDERATION

NHS West Suffolk NHS Foundation Trust

Criteria for referral to IPMS:

Prior to a considering a referral to the IPMS, current services in your area should be considered, such as:

Specialist Back and Neck Services, disease-specific pathways: https://www.westsuffolkccg.nhs.uk/clinical-area/clinical-guidance-and-pathways/, physiotherapy or local well-being services.

Only the following clinicians may refer patients to the IPMS:

- Consultants
- General Practitioners
- ESP Physiotherapists

Criteria	Explanation
Have had pain for a period of more than **6 months**.	A referral should be considered if the patient is not improving with optimised prescribed therapies in line with the WSCCG analgesic ladders: https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/
Musculoskeletal conditions that have been worked up thoroughly by MSK services.	All patients with MSK conditions must access standardised physiotherapy services prior to referral to the IPMS. If patients fail to respond to standard treatment, they should be considered for a referral to the IPMS.
All "red flags" have been ruled out	The IPMS is a routine service. Patients with suspected 'red flag' pathology should be referred to the appropriate specialist service within secondary care.
Patients have completed their involvement with other clinical services and are now discharged.	Patients should not be seeing other teams for the same problem as this hampers acceptance and often confuses pathways.
Patient has been thoroughly investigated for treatable pathology and the diagnostic pathway has been completed.	Patient acceptance and commitment to self-management strategies is hindered when they are expecting further investigations or a solution/cure for their pain.
Patient requires specialist assessment for medication management	Our specialist consultants offer specialist advice on areas such as renal/hepatic impairment and/or multiple medication intolerances.
Scope of care is beyond current WSCCG guidelines for primary care	https://www.westsuffolkccg.nhs.uk/clinical-area/practice-support/primary-care-commissioning/

Please do not refer patients to the IPMS if:

Exclusion Criteria	Explanation
Patients who are waiting to be seen by another specialty for the same problem	Patient acceptance and commitment to self-management strategies is hindered when they are expecting further investigation or a solution/cure for their pain.
Severe unstable psychiatric illness, severe personality disorders, severe untreated depression.[1]	This is unproductive for the patient and often results in a poor outcome. The IPMS clinical psychologists do not provide general psychology services. A referral to secondary care or wellbeing services should be considered in this instance.
Addiction to prescription medications or other recreational substances including alcohol.[1]	The patient needs to be stabilised by an addiction service and a referral to local addiction services should be considered. Once the patient is deemed stable, a referral to the IPMS may be considered.
Standalone injection therapy	The IPMS offers a multidisciplinary, holistic, biopsychosocial approach to self-management and there is strong evidence suggesting standalone injection therapy is ineffective.
Patients with outstanding litigation relating to injury or pain.[1]	This is often a barrier to the acceptance of self-management strategies.
Cancer pain	Referrals to the IPMS should come via oncology or palliative care
Patients under 16	Referrals to the IPMS should come via a paediatric specialist
Housebound patients.	We do not provide a home visiting service.
Patients awaiting definitive treatment for the problem, for instance awaiting surgery.	There is no point in embarking on a biopsychosocial pain management program, if a possible solution is still awaited. You can contact us directly if you require medication advice in the interim.

[1] This is not an absolute exclusion and will be based on a case by case basis in consultation with IPMS MDT.

20190912_PreReferral_Guidance_v4

- New guidance and proforma
- Uploaded to the DXS system

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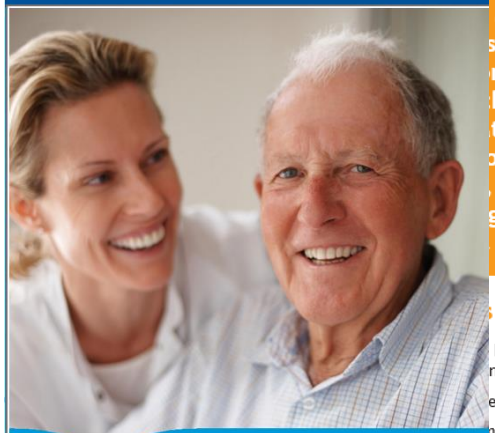
NHS Foundation Trust

CPD update for NMPs

CPD (1): health coaching dates

Coaching for Health and Wellbeing

Better conversations, better care



For more information visit:
www.betterconversation.co.uk

a long term condition can be challenging
sing - with people often seeking
m health/care professionals. Adding a
hing approach to the tool box of
tion skills you use in your conversations
omote self-sufficiency, satisfaction and
, enabling people to manage their health
g with greater independence and self-

long term conditions account for 50% of all GP appointments,
npatient bed days and 70% of overall NHS spend

ers of all deaths will be as a result of chronic disease by 2020.

nature deaths caused by detrimental health behaviours

What is coaching for health and wellbeing?

Health and wellbeing coaching is talking to people in a way that supports and empowers them to better manage their own care, fulfil self-identified health goals and improve their quality of life.

What are the benefits of coaching for health and wellbeing?

- Improves communication fundamental to care.
- Supports people living with long term conditions to prioritise their health and wellbeing.
- Enables practitioners to shine the spotlight on personal awareness and responsibility in a supportive manner, and transform the client/practitioner relationship
- Can increase self-sufficiency, satisfaction, confidence, motivation, compliance, and reduce costs for organisations.
- Participants report that this training is having a positive impact on their resilience

What skills will I learn?

You will learn a combination of tools and techniques you can use every day to support people with behaviour change. These include further developing your listening skills, exploring the use of rapport and challenge, as well as how to align meaningful goals to motivate and encourage the people you are working with

Who will benefit from this training?

These skills are widely applicable across a range of conditions but particularly in the following areas: those living with long term conditions, mild anxiety and depression, medication compliance, pain management, lifestyle changes, recovery and rehabilitation.

How does this fit with other priorities for me and my organisation?

The training will help you work towards addressing the following:

- Improving experience and quality of care
- Increasing Friends and Family test scores
- Reducing complaints especially around communication
- Reducing organisational costs and saving time
- Builds relationships with colleagues, and collaborative working
- Supports the delivery of integrated care and care planning
- Enhances local service plans for supporting people living with long term conditions

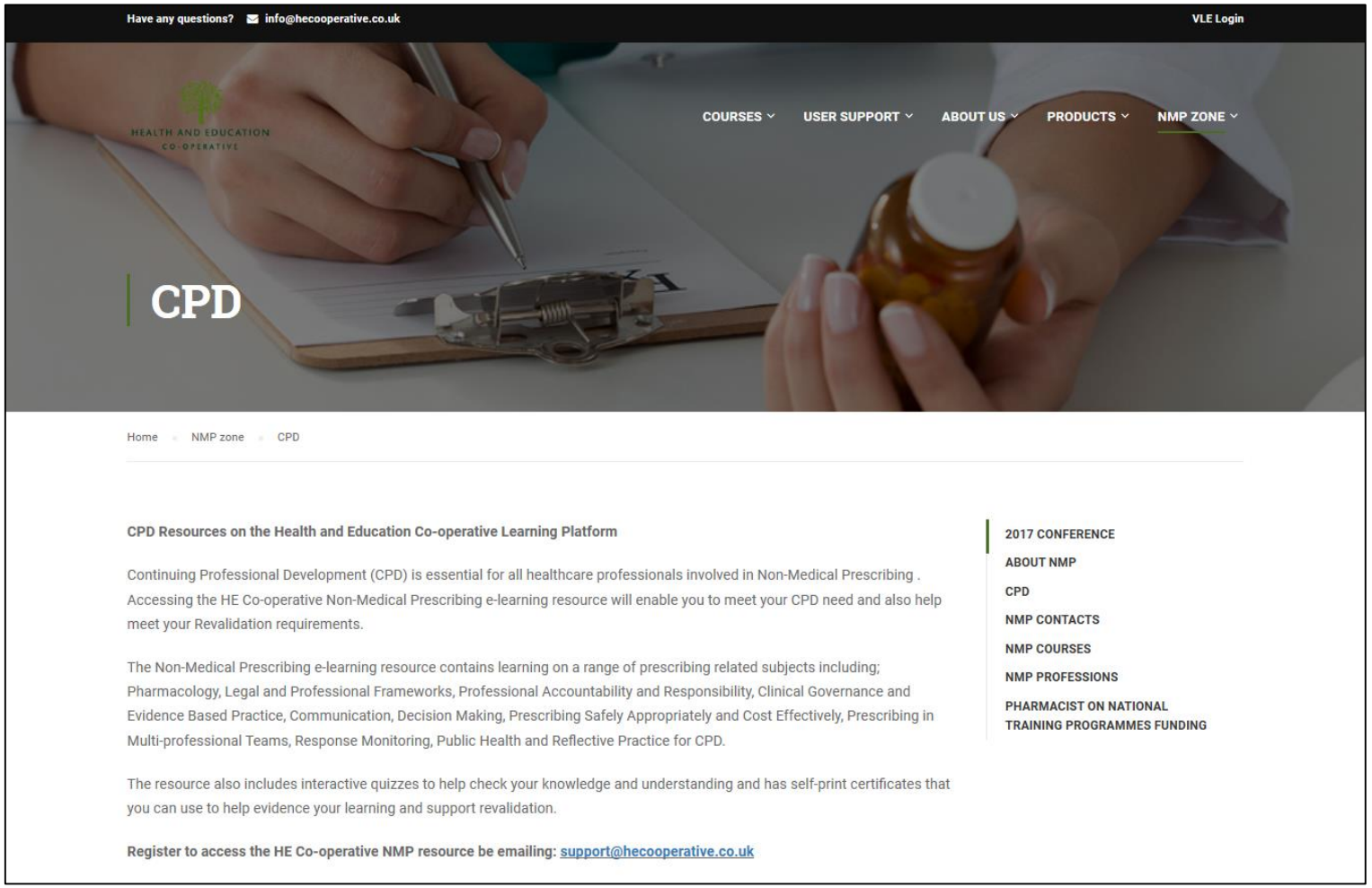
Course Dates 2019/2020:

The Health Coaching training is delivered over two days, one week apart.
Training days run from 9.15am – 5pm

31st Oct and 7th Nov 2019	- The Blackbourne, Elmswell (2 spaces remaining)
14th and 21st Nov 2019	- West Suffolk House, Bury St Edmunds (Full)
5th and 12th Dec 2019	- The Blackbourne, Elmswell (Full)
9th and 16th Jan 2020	- Stow Lodge Centre room, Stowmarket (Full)
11th and 18th Feb 2020	- The Blackbourne, Elmswell (Full)
20th and 26th Feb 2020	- West Suffolk House, Bury St Edmunds
3rd and 10th March 2020	- The Blackbourne, Elmswell
12th and 19th March 2020	- Stow Lodge Centre, Stowmarket
9th and 16th April 2020	- West Suffolk House, Bury St Edmunds
21st and 28th April 2020	- East Suffolk House, Woodbridge
14th & 28th May 2020	- West Suffolk House, Bury St Edmunds
11th& 18th June 2020	- West Suffolk House, Bury St Edmunds

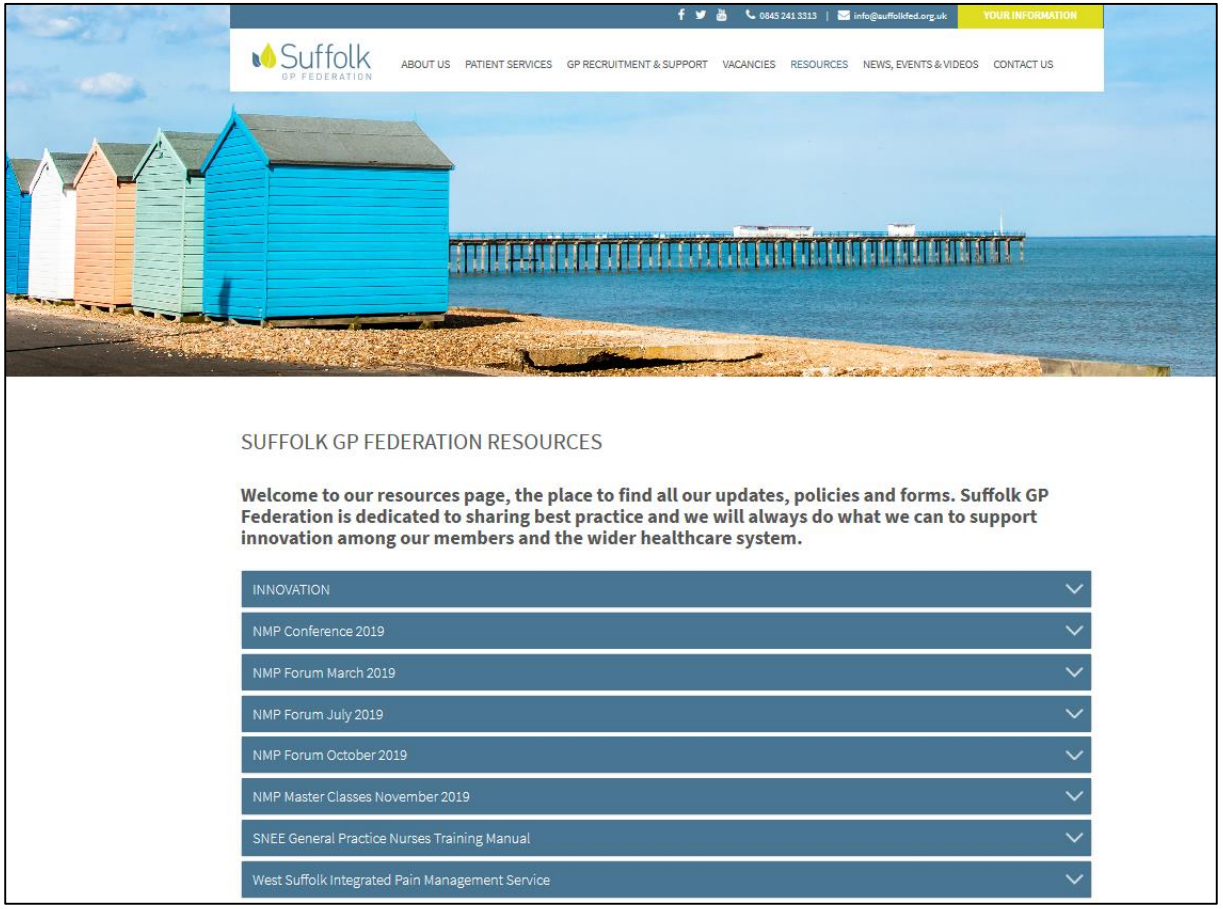
Health.Coaching@wsh.nhs.uk

CPD (2): NMPs



https://www.hecooperative.co.uk/nmp-zone/cpd/

CPD (3): SGPF website: resources to support education and training



https://suffolkfed.org.uk/resources/

CPD (4) : PrescQIPP e-learning courses

CPD (5): hold the dates

NMP forum

Venue: Stow Lodge
Time: 9.30-12.45
Dates:
Thursday 5th March 2020
Wednesday 3rd June 2020
Friday 9th October 2020

NMP master class

Venue: Stow Lodge
Time: 9.30-12.45
Dates: (half day sessions)
Friday 15th November 2019
Tuesday 21st April 2020
Friday 27th November 2020
All meetings 09:30 – 12:45hrs: Stow Lodge Centre, Pod Room 1

Next NMP Conference Monday 6th July 2020 @UOS

CPD (6): NMP conference

	NMC Conference 2020 Ideas for topics and speakers
1	Suggested topics and speakers for main plenary sessions *Professional topics:* *Legal topics* *Clinical topics* *Local prescribing update topics*
2	Suggested topics and speakers for workshops
3	If you would like to participate in the 2020 NMP conference with presenting a plenary session or facilitating a workshop please provide details of subject area and contact details

Next NMP Conference Monday 6th July 2020 @UOS

Thank you

Further information and additional references

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