Demonstrating competence and using the national prescribing framework

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March 2019

Outline

1. The updated framework
   - the updated framework: what has changed?
   - using the framework to demonstrate competence in non medical prescribing practice
2. Developing the team
   - implementing the framework within different professional groups
   - supporting non medical prescribers: infrastructure needed to support the safe and effective development and implementation of non medical prescribing
   - developing advanced roles and services around prescribing
3. Keeping up to date
   - ensuring you have the history-taking, clinical assessment and diagnosis skills
   - keeping your prescribing knowledge up-to-date: accessing education, training and resources

ROYAL PHARMACEUTICAL SOCIETY

Prescribing competency framework

Catherine Picton, Lead author

Improving Nurse Prescribing Practice and competence: Using the national prescribing competency framework

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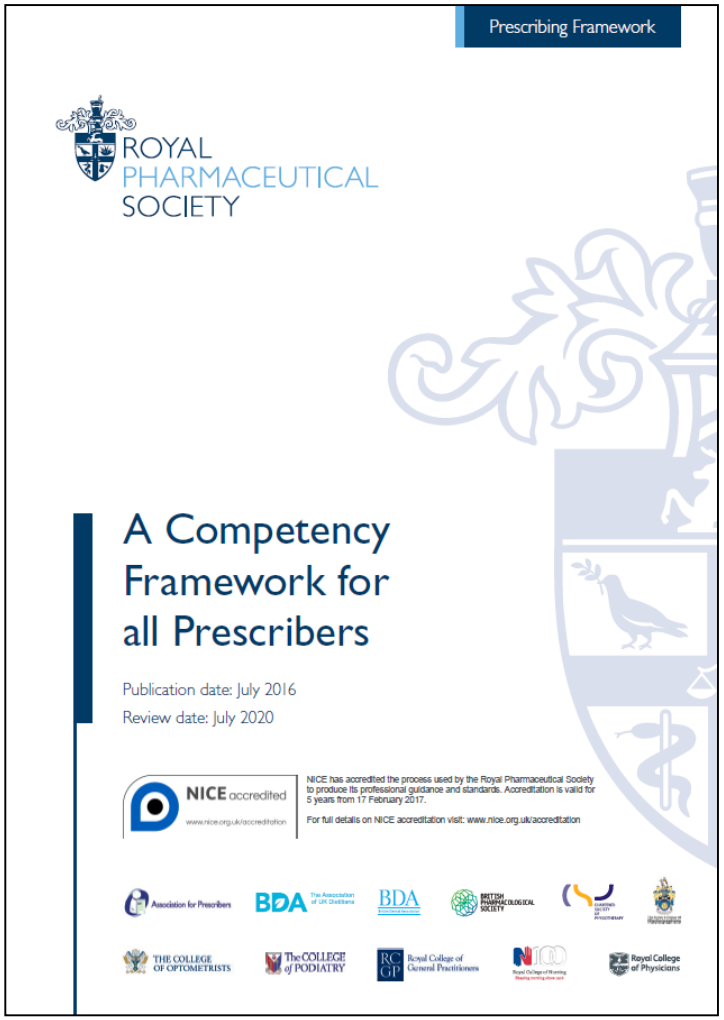
Competency Framework for all Prescribers (RPS 2016)



Who will use the framework?

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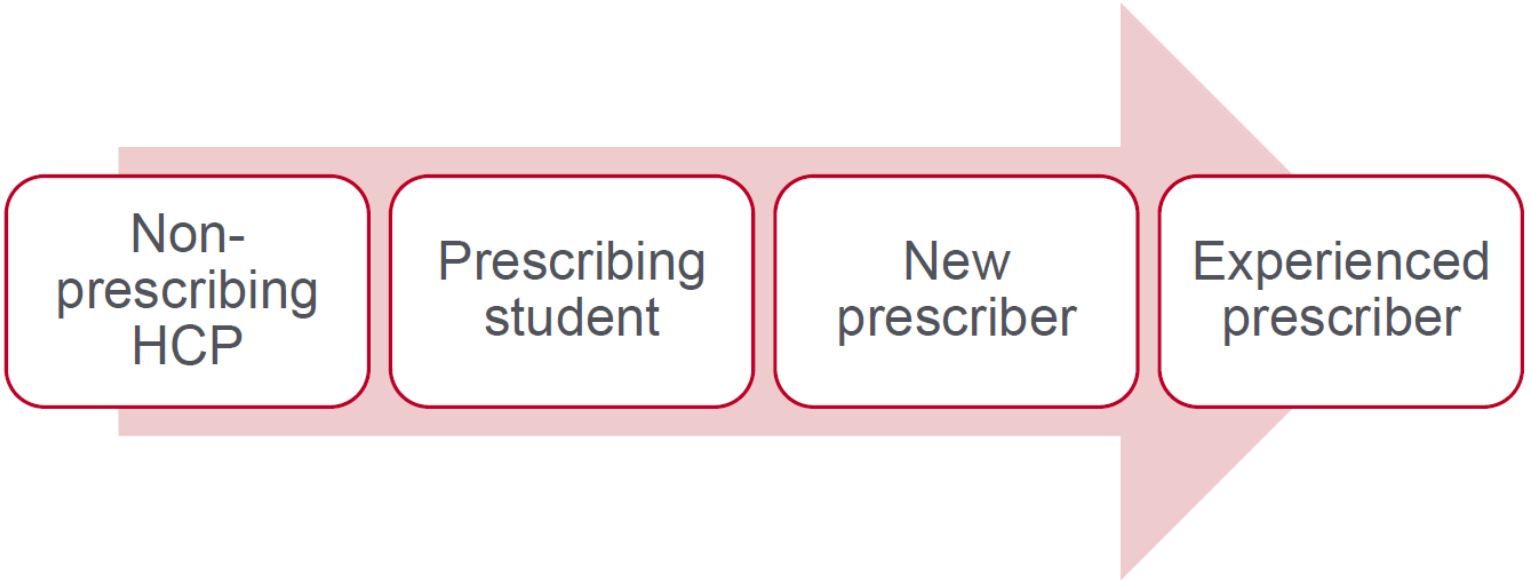
THE UPDATED FRAMEWORK



What is competence?

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INTERPRETING FRAMEWORKS

- Competence[1]
  - "the ability to do something successfully or efficiently"
- Competent[1]
  - "having the necessary ability, knowledge, or skill to do something successfully"
- Competency[2]
  - "…quality or characteristic of a person that is related to effective performance."

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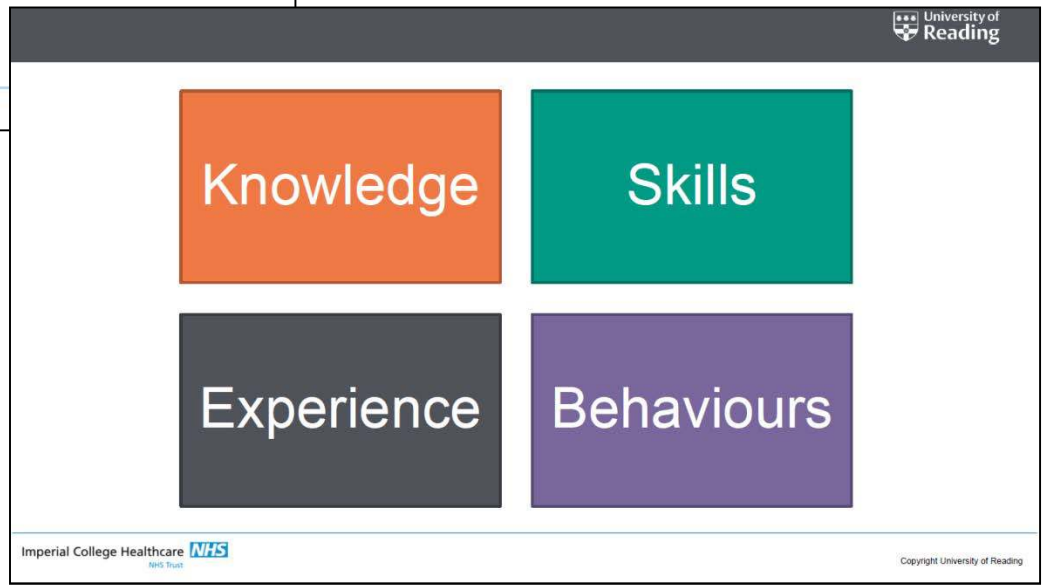

How can the framework be used?

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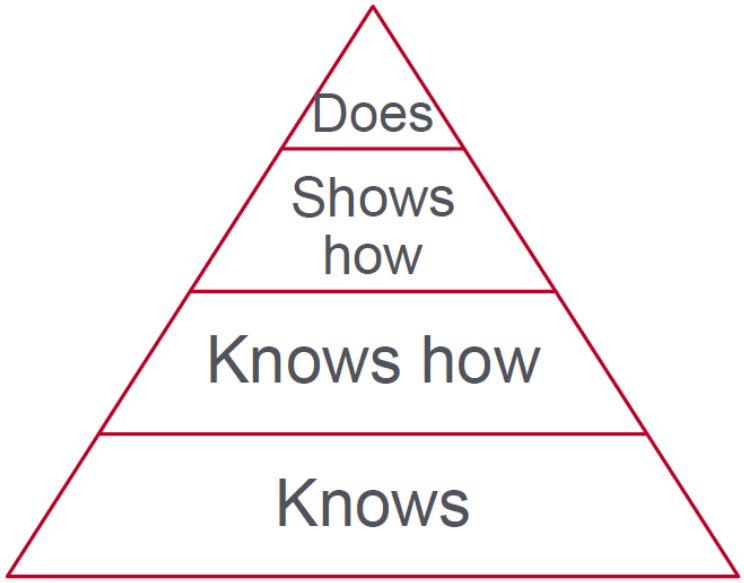
MILLER'S PYRAMID[3] (CLINICAL COMPETENCE)



Demonstration in real life i.e. practice
Observations, workplace based assessments

Demonstration of application of facts
OSCEs, simulation

Application of facts
Essays, case studies, presentations

Facts
MCQs

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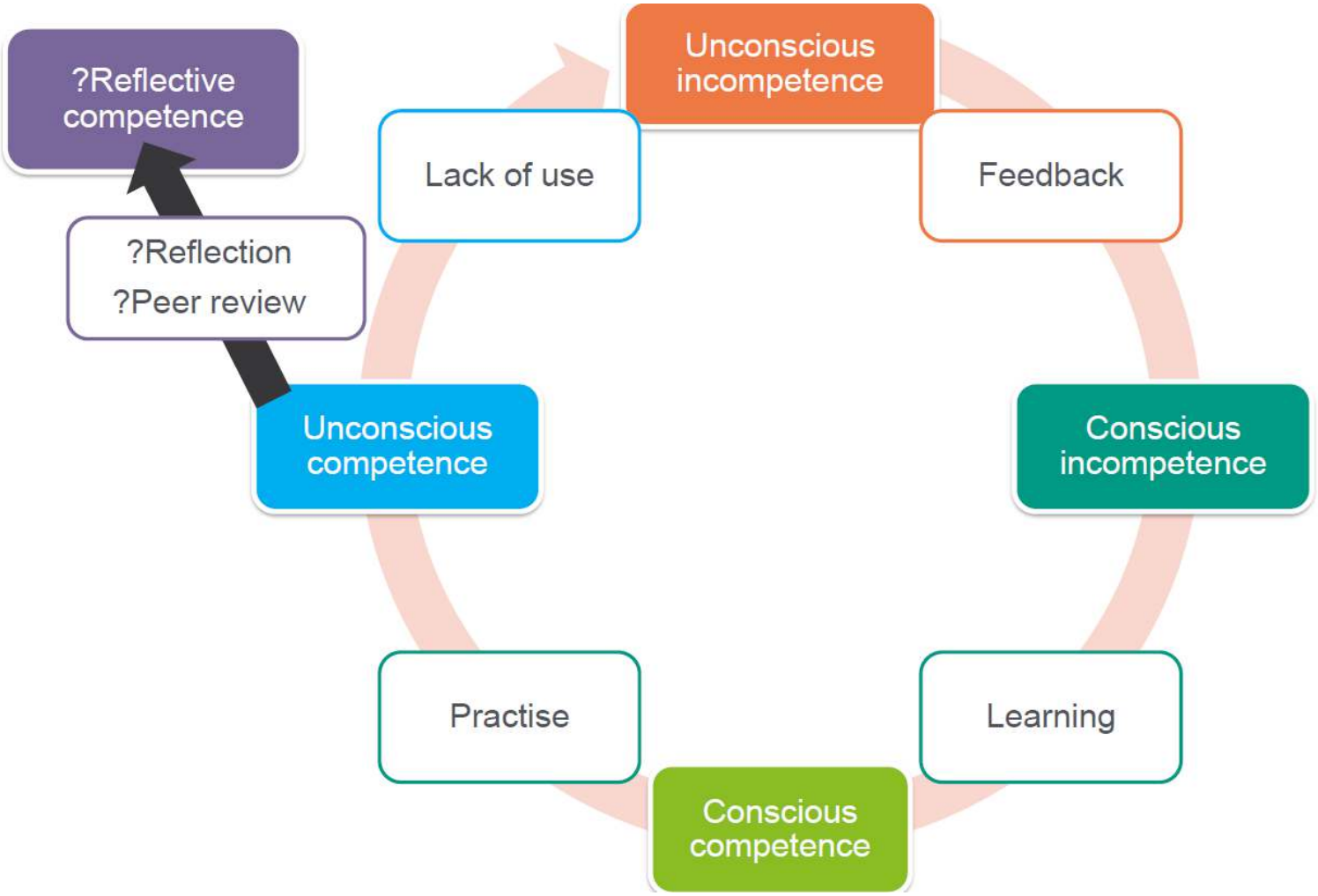
How can the framework be used?



How can the framework be used?

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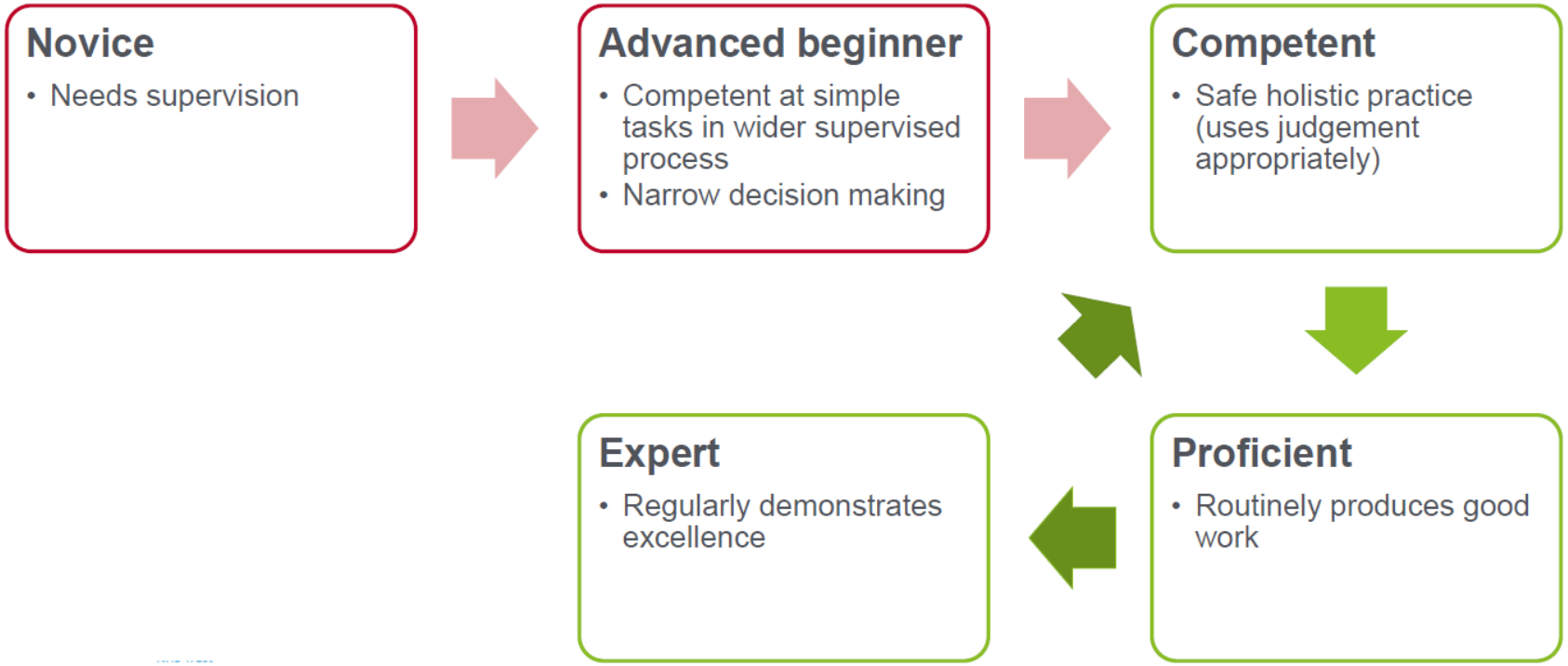
DREYFUS MODEL OF SKILL ACQUISITION[4]



Uses of the competency framework

- If acquired and maintained, the prescribing competencies in this framework, will help healthcare professionals to be safe, effective prescribers who are able to support patients to get the best outcomes from their medicines.
- The framework can be used by any prescriber at any point in their career to underpin professional responsibility for prescribing.
- The framework can be used to support revalidation.

* It can also be used by **regulators**, education providers, professional organisations and specialist groups to inform standards, the development of education, and to inform guidance and advice.

* It provides the opportunity to bring professions together and harmonise education for prescribers by offering a competency framework for all prescribers.

National Prescribing Competency Framework

Alexander 2018

Using the prescribing competency dimensions for nurse prescribing practice

Use the framework to:

- Train to become a prescriber
- Develop a 'learning contract' for your CPD
- Ensure that the key behaviours are 'always events'
- Support and mentor aspiring non-medical prescribers
- Extend or change your scope of practice

National Prescribing Competency Framework

Alexander 2018

The Competency Framework for all Prescribers

THE CONSULTATION	PRESCRIBING GOVERNANCE
1. Assess the patient	7. Prescribe safely
2. Consider the options	8. Prescribe professionally
3. Reach a shared decision	9. Improve prescribing practice
4. Prescribe	10. Prescribe as part of a team
5. Provide information	
6. Monitor and review	

Key changes to updated framework

(Hall 2019)

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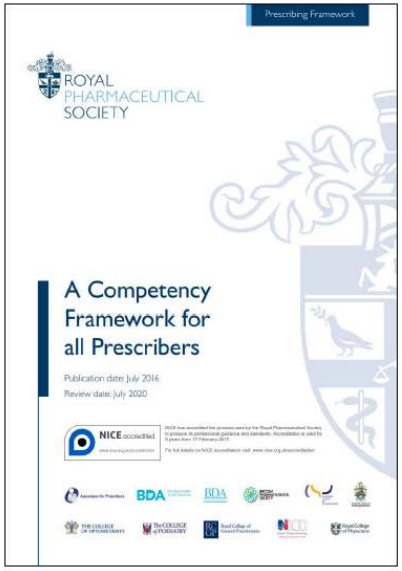
PRESCRIBING COMPETENCY FRAMEWORK



What are the key changes/messages for you?

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Key changes to updated framework

(Hall 2019)

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"OPINION POLL"

1. Treatment options (1.1, 2.2, 2.5)
2. Working in partnership (3.1, 3.3, 3.6, 5.1)
3. Electronic systems and remote prescribing (4.9, 4.10, 7.3)
4. Information management (5.3, 7.2, 7.5)
5. Risk management (7.4)

Key changes to updated framework

(Hall 2019)

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1. TREATMENT OPTIONS

- **1.1** Take an appropriate medical, social and medication* history

  ** This includes current and previously prescribed and non-prescribed medicines, on-line medicines, supplements, complementary remedies, illicit drugs and vaccines*

- **2.2** Considers all pharmacological treatment options including optimising doses as well as stopping treatment (appropriate polypharmacy, deprescribing)
- **2.5** Assesses how co-morbidities, existing medication, allergies, contraindications and quality of life impact on management options

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Key resources to help with tackling inappropriate polypharmacy and deprescribing

(Hall 2019)

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1. RESOURCES

Guidance

- NICE guideline on multi-morbidity
  - www.nice.org.uk/guidance/ng56/resources
- PrescQIPP webkit
  - www.prescqipp.info
- 7-steps approach
  - http://www.polypharmacy.scot.nhs.uk/7-steps/

Prescribing tools

- STOPP/START
- NO TEARS
- Beers Criteria
- MAI tool

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Key changes to updated framework

(Hall 2019)

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2. WORKING IN PARTNERSHIP

- **3.1** Works with the patient/carer in partnership to make informed choices, agreeing a plan that respects patient preferences including their right to refuse or limit treatment
- **3.3** Explains the rationale behind and the potential risks and benefits of management options in a way the patient/carer understands
- **3.6** Explores the patient/carers understanding of a consultation and aims for a satisfactory outcome for the patient/carer and prescriber.
- **5.1** Checks the patient/carer's understanding of and commitment to the patient's management, monitoring and follow-up

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Key resources to support shared decision making (Hall 2019)

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2. RESOURCES

- What care would you, your friends and your family want?

- EBM + patient centred practice = values based practice
  - http://valuesbasedpractice.org/
  - NES module on values based practice in mental health
  - www.nes.scot.nhs.uk/media/417158/mental_health_module_4.pdf

Key resources to support shared decision making (Hall 2019)

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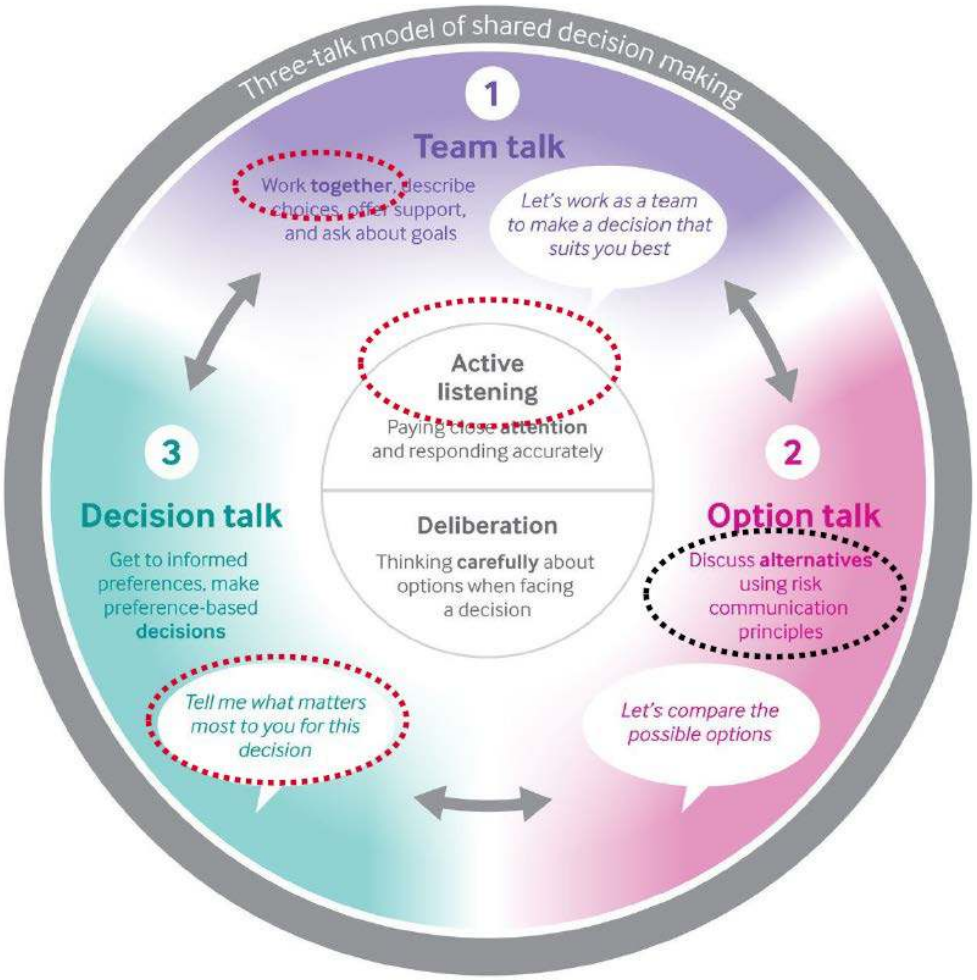
2. RESOURCES

- NHS RightCare Patient Decision Aids
  - www.england.nhs.uk/rightcare/shared-decision-making/
- Centre for Shared Decision Making
  - http://med.dartmouth-hitchcock.org/csdm_toolkits.html
- Teach Back technique
  - www.teachbacktraining.org/
  - https://www.youtube.com/watch?v=bzpJJYF_tKY

Key resources to support shared decision making (Hall 2019)



Three-talk model of shared decision making, 2017.
Glyn Elwyn et al. BMJ 2017;359:bmj.j4891

Key resources to support updated framework

(Hall 2019)

- Informed consent

Key changes to updated framework

(Hall 2019)

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4. INFORMATION MANAGEMENT

- **5.3** Guides patients/carers on how to identify reliable sources of information about their medicines and treatments

- **7.2** Knows about common types and causes of medication errors and how to prevent, avoid and detect them
- **7.5** Keeps up to date with emerging safety concerns related to prescribing

Key resources to support information giving (Hall 2019)

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4. RESOURCES

- Behind the Headlines
  - www.nhs.uk/news/
- Clinical Knowledge Summaries (CKS)
  - https://cks.nice.org.uk

Keeping up to date

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KEEPING UP-TO-DATE

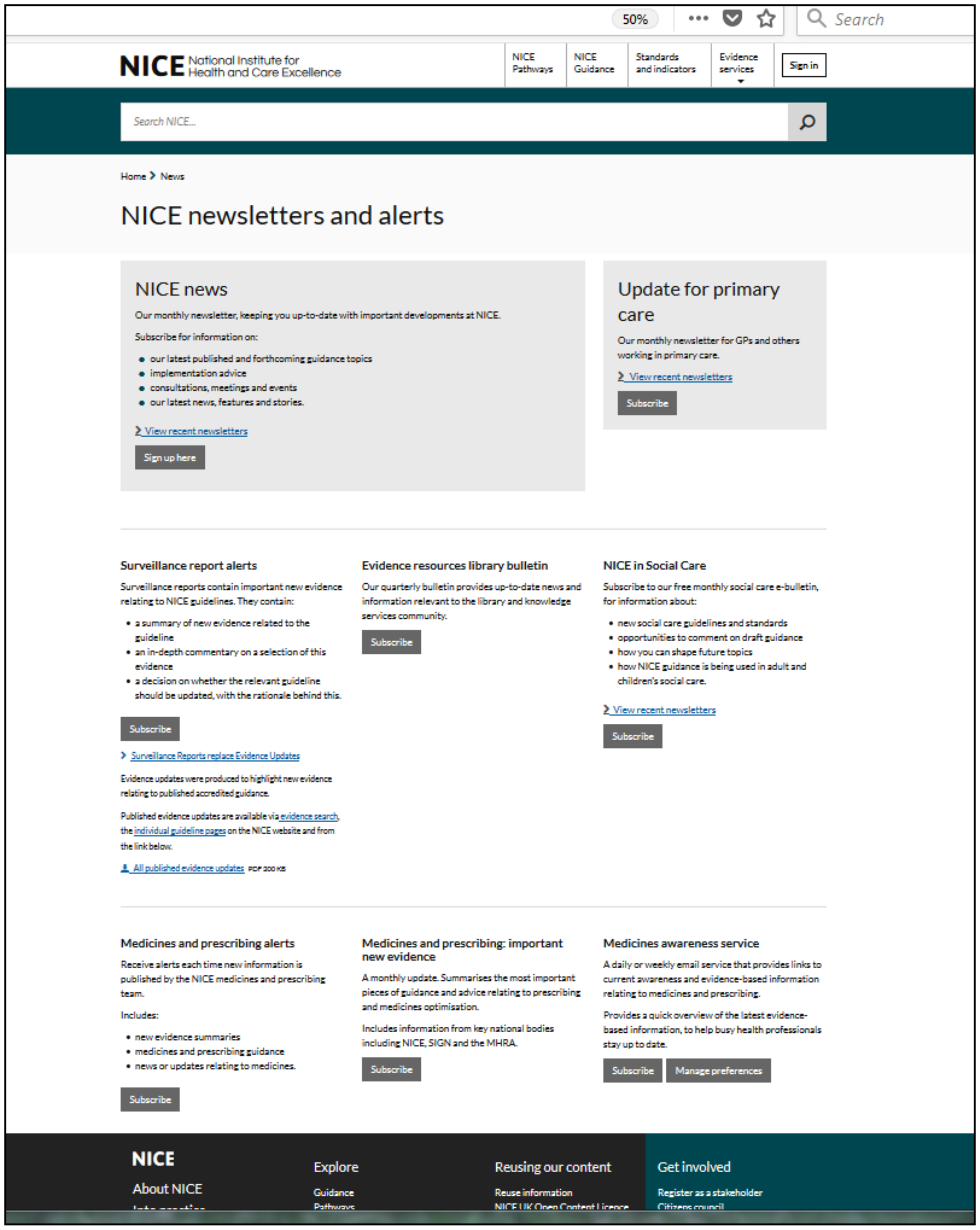
- Professional bodies / special interest groups
  - Email updates
  - Annual conferences
  - Study days
  - Online forums
- Concise, summarised updates from organisations linked to your clinical specialism(s)
  - e.g. NICE www.nice.org.uk/news/nice-newsletters-and-alerts
    - Medicines and prescribing alerts, guidance updates etc.

Keeping up to date

Alexander 2018

Keeping your knowledge up-to-date: accessing education, training and resources

- Do you get regular up dates from NICE www.nice.org.uk/news/nice-newsletters-and-alerts
  - Medicines and prescribing alerts - each time new information is published by the NICE medicines and prescribing team
  - Medicines and prescribing: important new evidence - A monthly update. Summarises the most important pieces of guidance and advice relating to prescribing and medicines optimisation.
  - Medicines awareness service - daily or weekly email service that provides links to current awareness and evidence-based information relating to medicines and prescribing.



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Using the framework

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USING FRAMEWORKS

1. Review the framework in your context
   - For your practice
   - For your workplace
   - For you patients
2. Decide which statements you feel are essential for your practice
   - Decide which are desirable
   - If you think any are not applicable you need to be able to justify this
3. Talk to your peers
   - Learn from their experiences – they will help shape your next steps

Using the framework

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USING FRAMEWORKS

4. Draft your next steps
   - *Action plan/learning needs assessment/learning contract/PDP/revalidation*
   - Who will support you?
   - What resources do you need?
   - How long do you need?
5. Discuss this with your mentor/line manager/workplace supervisor
6. Finalise your plan and review regularly
   - When do you need to review and when do you need to re-write your plan?
   - Feedback to your peers

Application of framework to practice

2.2 Considers all pharmacological treatment options including optimising doses as well as stopping treatment (appropriate polypharmacy, deprescribing)

3.1 Works with the patient/carer in partnership to make informed choices, agreeing a plan that respects patient preferences including their right to refuse or limit treatment

3.3 Explains the rationale behind and the potential risks and benefits of management options in a way the patient/carer understands

7.5 Keeps up to date with emerging safety concerns related to prescribing

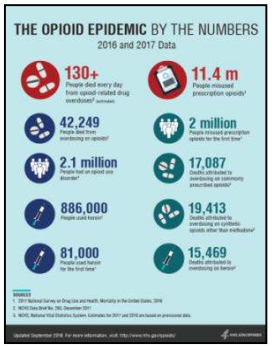

ISCHGL
HELSINKI
KM 1734
Enkenbach-Alsenborn
327,39 km
HANNA
NICKELBACK
BANGKOK
667 km
Meppen-Versen
KAPSTADT
KM 9230
SOLTAU
SOUTHPOLE
KM 15130
Feuerwehr Eibelshausen 643 Km
Schneemänner
TOKYO
KM 9940
Wapen van Roosendaal
Hattenhof - Kalbach - Bucheller 514km
Peuerbach
300,5 km
Klotten 652 km
Hääschd

The framework journey

- Working in collaboratively with HCPs across professional and geographical boundaries
- Assisted with the development of local guidance for safer prescribing of opioids and opioid tapering
- Lobbied for resources to be available on a national website
- Disseminated information/ guidance: 1:1, workshops, conferences and through publications

USA: Opioid misuse epidemic

US opioid misuse epidemic



- 11% Americans (adults) experienced chronic pain (CDC 2016)
- Over prescribing of opioids has led to enormous societal problems in USA (Ballantyne 2012)
- National epidemic of opioid related overdoses, deaths and addictions (Volkow & McLellan 2016)
- **2016:** Overdoses involving opioids killed more than 42,249 people. 40% of those deaths were from prescription opioids (Hedegaard et al 2017)
- **2017:** 70,237 drug overdose deaths: Opioids were involved in 47,600 overdose deaths (67.8% of all drug overdose deaths) (CDC 2018)
- On average, 130 Americans die every day from an opioid overdose (CDC 2018)

Evening Standard: March 2018

https://assets.standard.co.uk/opioids/index.html

1. Cost

- £263 million of tax payers money spent in England in 2017 on prescription opioids

2. Increase in prescriptions

- 90% prescribed by GPs - GPs prescribe twice as many opioids as they did 10 years ago
- 90% of nearly 24 million opioids prescribed annually are for chronic non-cancer pain

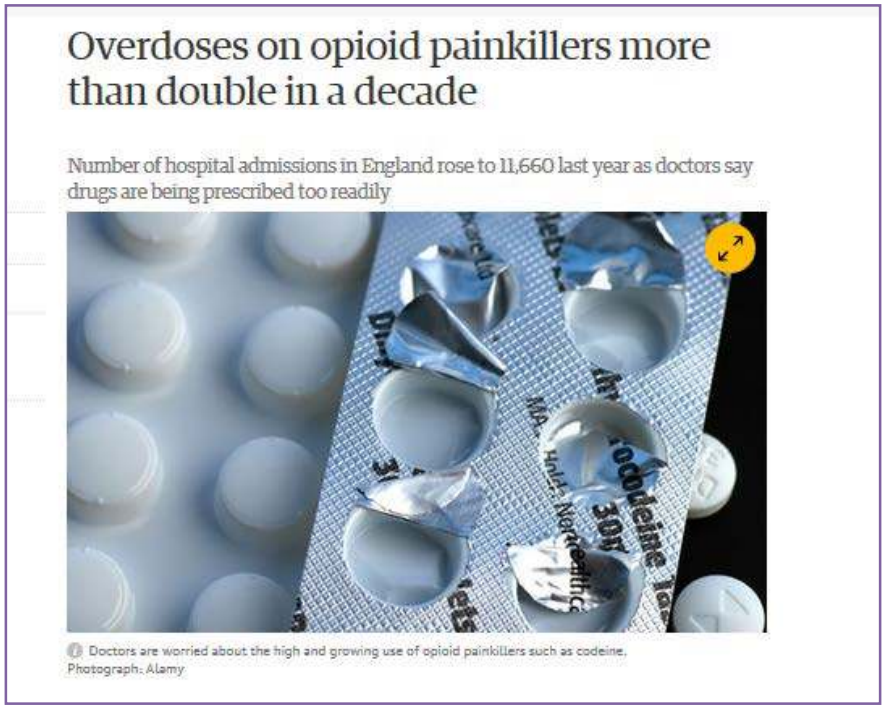
3. Limited effectives

- 90% of opioids prescribed do not work for chronic non-cancer pain

4. Risks

- 300,000 people in the UK are said to be problem users

Overdose – prescription opioids



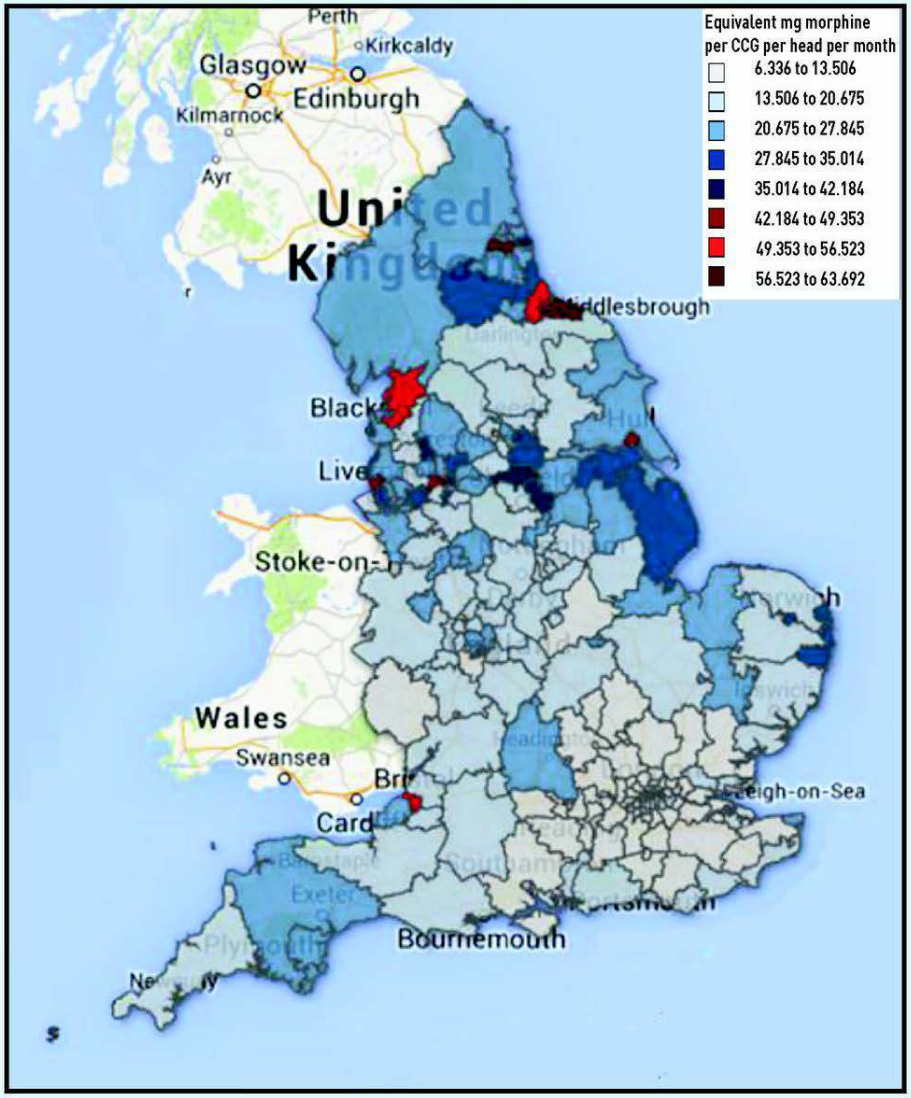
Overdoses on opioid painkillers more than double in a decade

Number of hospital admissions in England rose to 11,660 last year as doctors say drugs are being prescribed too readily

Doctors are worried about the high and growing use of opioid painkillers such as codeine. Photograph: Alamy

The number of people attending hospital with poisoning from opioids more than doubled to 11,000 between 2005-06 and 2015-16 (NHS Digital. Note: 2016-17 data provisional).

Variation in English CCGs in opioid prescribing in equivalent mg of morphine from August 2010 to February 2014



Luke Mordecai et al. Br J Gen Pract
doi:10.3399/bjgp18X695057

BJGP British Journal of General Practice
bringing research to clinical practice

Opioids Aware; an audit of general practice prescribing of high dose opioids in NHS England Midlands and East (E)

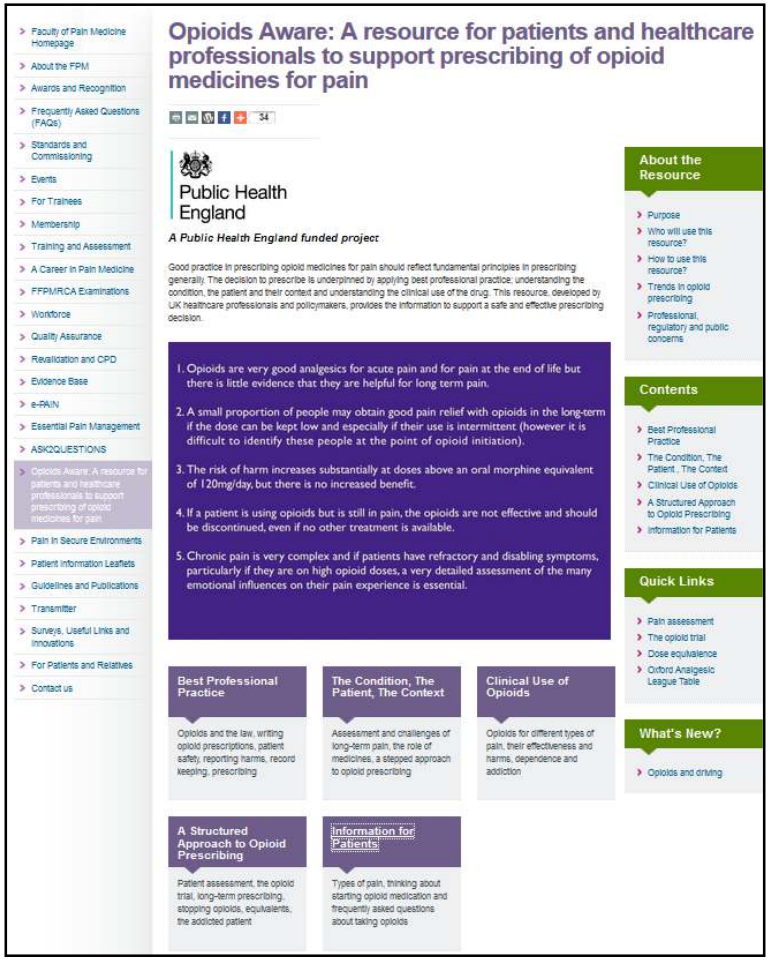
Data analysis of the first 74 responders

Findings from the first 74 practices, representing 663,418 patients

Findings	
Patients were identified as being on high dose opioids	**1022 patients** **0.16% of the population**
Prescription for high dose opioids for chronic pain	**87% of all high dose opioid prescriptions** **0.13% of the population**
Indication for prescriptions was not clear in	**34%**
Evidence of overuse or misuse in	**6.8%**
Not had a medication review in the last 3 months	**52%**
Co prescribed a gabapentinoid drug	**42%**
Co prescribed a Z drug	**14.3%**
Co prescribed a benzodiazepine	**14%**

Opioids Aware

2015



www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

1. Opioids are very good analgesics for acute pain and end of life pain but there is little evidence that they are helpful for long-term pain.

2. A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent, but it is difficult to identify these people at the start of treatment.

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120 mg/day, but there is no increased benefit.

4. Opioids should be discontinued if the person is still in pain despite using opioids, even if no other treatment is available.

5. A detailed assessment of the emotional influences on the person's pain experience is essential for people with chronic pain who also have refractory and disabling symptoms, particularly if they are on high opioid doses.

Recognising the patient on high doses of opioids

	Prescription	Guesstimate of oral MED/d	Calculated dose of oral MED/d
1.	OxyCodone modified release 60 mg twice a day		
2.	Fentanyl transdermal patch 75 microgram hour		
3.	Buprenorphine transdermal patch 70 microgram an hour		
4.	Tramadol 100 mg four times a day		
5.	Buprenorphine 20 microgram an hour plus codeine 60 mg four times a day		

MED/d = Morphine equivalent dose / day

Approximate equi-analgesic potencies of opioids for oral administration

	Potency ration with oral morphine	Equivalent dose to 10mg oral morphine
Codeine phosphate	0.1	100mg
Dihydrocodeine	0.1	100mg
Hydromorphone	7.5	1.3mg
Methadone	*	*
Morphine	1	10mg
Oxycodone	2	5mg
Tapentadol	0.4	25mg
Tramadol	0.15	67mg

Transdermal buprenorphine changed every three or four days (twice weekly)

	35 microgram/hr	52 microgram/hr	70 microgram/hr
Morphine sulphate (mg/day)	84mg	126mg	168mg

Transdermal Opioids

A. Buprenorphine

Transdermal buprenorphine changed at weekly intervals

	5 microgram/hr	10 microgram/hr	20 microgram/hr
Codeine phosphate (mg/day)	120mg	240mg	
Tramadol (mg/day)	100mg	200mg	400mg
Morphine sulphate (mg/day)	12mg	24mg	48mg

https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware/structured-approach-to-prescribing/dose-equivalents-and-changing-opioids

Recognising the patient on high doses of opioids

	Prescription	Guesstimate of oral MED/d	Calculated dose of oral MED/d
1.	OxyCodone modified release 60 mg twice a day		240 mg MED/d
2.	Fentanyl transdermal patch 75 microgram hour		270 mg MED/d
3.	Buprenorphine transdermal patch 70 microgram an hour		168 mg MED/d
4.	Tramadol 100 mg four times a day		60 mg MED/d
5.	Buprenorphine 20 microgram an hour plus codeine 60 mg four times a day		72 mg MED/d

MED/d = Morphine equivalent dose / day

Dose equivalence charts

integrated working

NHS
West Suffolk
Clinical Commissioning Group

OPIOID EQUIVALENCE, RISKS AND RECOMMENDATIONS [1-3]

The information in the table below applies to non-cancer chronic pain in adults

OPIOID	Dose of stated opioid approximately equivalent in oral morphine equivalent dose/ day (MED/d)				
	Oral morphine < 50 mg per day	Oral morphine 50 - <100 mg per day	Oral morphine 100 mg per day	Oral morphine 120 mg per day	Oral morphine 200 mg per day
Oxycodone	<12.5 mg bd = <50 mg	< 25 mg bd = <100 mg	25 mg bd = 100 mg	30 mg bd = 120 mg	50 mg bd = 200 mg
Fentanyl transdermal patch	12 mcg/hr = 45 mg	25 mcg/hr = 90 mg	25 mcg/hr = 90 mg	50 mcg/hr = 180 mg	75 mcg/hr = 270 mg 100 mcg/hr = 360 mg
Buprenorphine transdermal patch	20 mcg/hr = 48 mg 10 mcg/hr = 24 mg	35 mcg/hr = 84 mg	35 mcg/hr = 84 mg	52 mcg/hr = 126 mg	70 mcg = 168 mg
Tapentadol	50 mg bd = 40 mg	100 mg bd = 80 mg	100 mg bd = 80 mg	150 mg bd = 120 mg	250 mg bd = 200 mg
Tramadol	50 mg qds = 30 mg	100 mg qds = 60 mg			
Codeine	60 mg qds = 24 mg				

RISK OF HARM

Patient factors: Pregnancy, age ≥65, anxiety or depression, overdose history, personal or family history of alcohol, substance/opioid misuse, renal and hepatic impairment, COPD or underlying respiratory conditions.
Drug factors: Multiple opioids, multiple formulations of opioids, more potent opioids, concurrent prescriptions of benzodiazepines/CNS depressants.

- Dosages ≥ 120 mg oral MED/d the risk of harm is substantially increased without increased benefit.
- Opioid related overdose risk is dose-dependent.
- Dosages of 50-<100 mg MED/d increases the risk for opioid overdose by factors of 1.9 to 4.6 compared with 1-<20 mg MED/d.
- Dosages ≥ 100 mg MED/d increases the risk of overdose significantly: 2.0-8.9 compared with 1-<20 mg MED/d.

DRIVING

- Patients may be particularly vulnerable to impairment when first starting a pain medication, following dose adjustments (up or down), when another drug is added or opioid taken in conjunction with alcohol.
- All opioid medicines have the potential to impair driving. A patient on high dose morphine (around 200-220 mg/ 24 hours) driving could be as impaired as someone with blood alcohol around the level above which it is illegal to drive. Alcohol and sedatives may impair driving at a lower morphine dose.

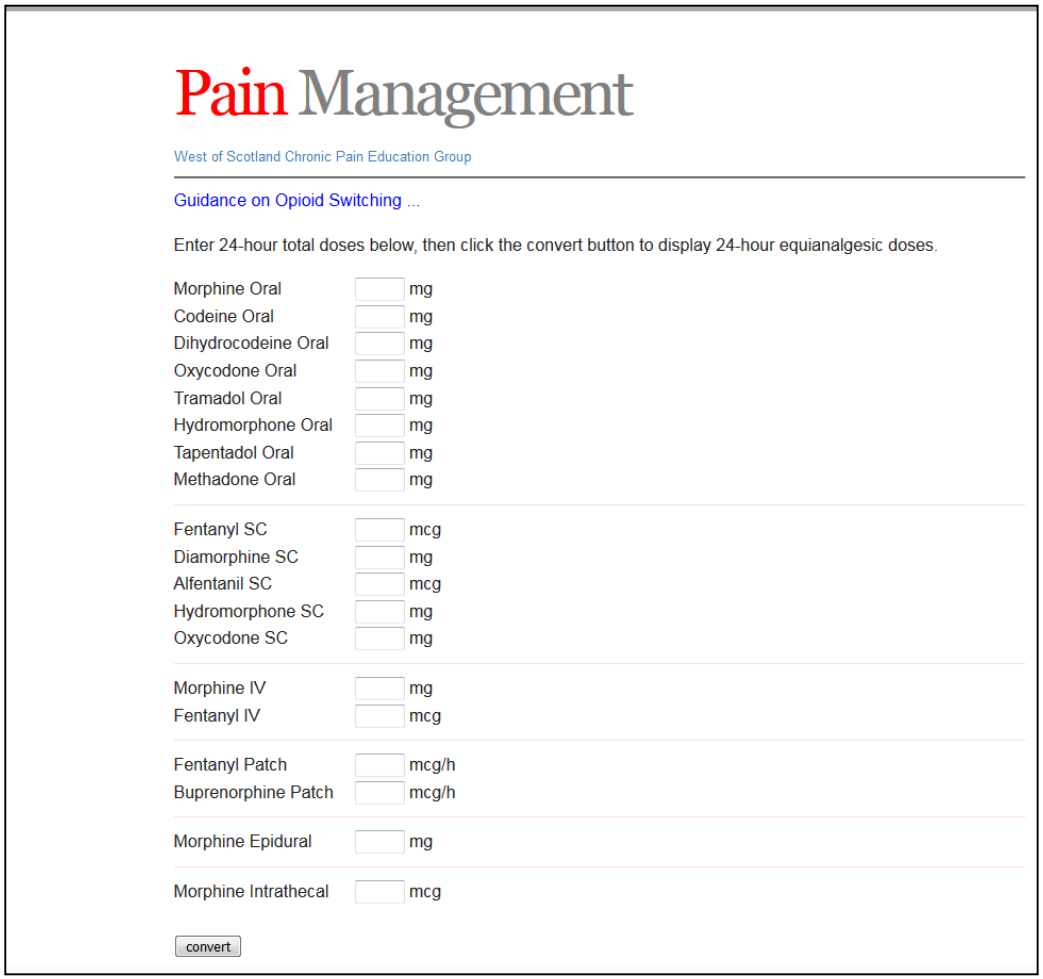
RECOMMENDATIONS

Undertake polypharmacy medication review, assess whether benefits outweigh risks and whether opioid trial goals are still being met. Consider opioid tapering and discontinuation.
There may be a role for medium term, low dose opioid therapy in carefully selected patients who can be monitored. Provide patient information leaflets.

References:
1. Opioids Aware 2. CDC Guidelines for Prescribing Opioids for Chronic Pain United States 2016, 3. IASP Statement on Opioids 2018

Produced by the WSCCG Medicines Management Team and West Suffolk Integrated Pain Management Service.
Version 1 March 2018. Review Date March 2020.

Dose equivalence calculator



Pain Management

West of Scotland Chronic Pain Education Group

Guidance on Opioid Switching ...

Enter 24-hour total doses below, then click the convert button to display 24-hour equianalgesic doses.

Morphine Oral		mg
Codeine Oral		mg
Dihydrocodeine Oral		mg
Oxycodone Oral		mg
Tramadol Oral		mg
Hydromorphone Oral		mg
Tapentadol Oral		mg
Methadone Oral		mg
Fentanyl SC		mcg
Diamorphine SC		mg
Alfentanil SC		mcg
Hydromorphone SC		mg
Oxycodone SC		mg
Morphine IV		mg
Fentanyl IV		mcg
Fentanyl Patch		mcg/h
Buprenorphine Patch		mcg/h
Morphine Epidural		mg
Morphine Intrathecal		mcg

convert

Recommended by NHS Scotland
http://paindata.org/calculator.php

Opioids Aware: risk of adverse selection

Opioids Aware 2015; Sullivan 2012

Adverse selection is where 'the most risky drug regimes are prescribed to the patients most likely to be harmed by them' Stannard 2018 BJA 120(6) 1148

Risk of running into problems with high dose opioids

Patient factors

- Depression/common mental health diagnoses (x 3-4)
- Alcohol misuse/non-opioid misuse (x 4-5)
- Opioid misuse (x 5-10)

Drug factors

- High doses
- Multiple opioids
- More potent opioids (Schedule 2)
- Concurrent benzodiapines/sedative/hypnotic drugs

Pain and opioid effectiveness

Opioids Aware 2015

Opioids are effective for:

- ✓ Surgical pain
- ✓ Trauma
- ✓ Child birth
- ✓ Cancer pain

IASP strongly advocates for access to opioids for the humane treatment of severe short-lived pain, using reasonable precautions to avoid misuse, diversion, and other adverse outcomes (IASP 2018).

Chronic pain and opioid effectiveness

In trials:

- Most medicines for long-term pain only benefit around one in every four or five people and on average only provide a 30% reduction in pain
  (Opioids Aware 2015).

- **Clinical practice**: **probably fewer than one in ten patients** prescribed opioids in real life….will be helped much at all, with benefit being modest at best but potentially life changing for the better when it occurs (Stannard 2018 BJA 120 (6) 1148).

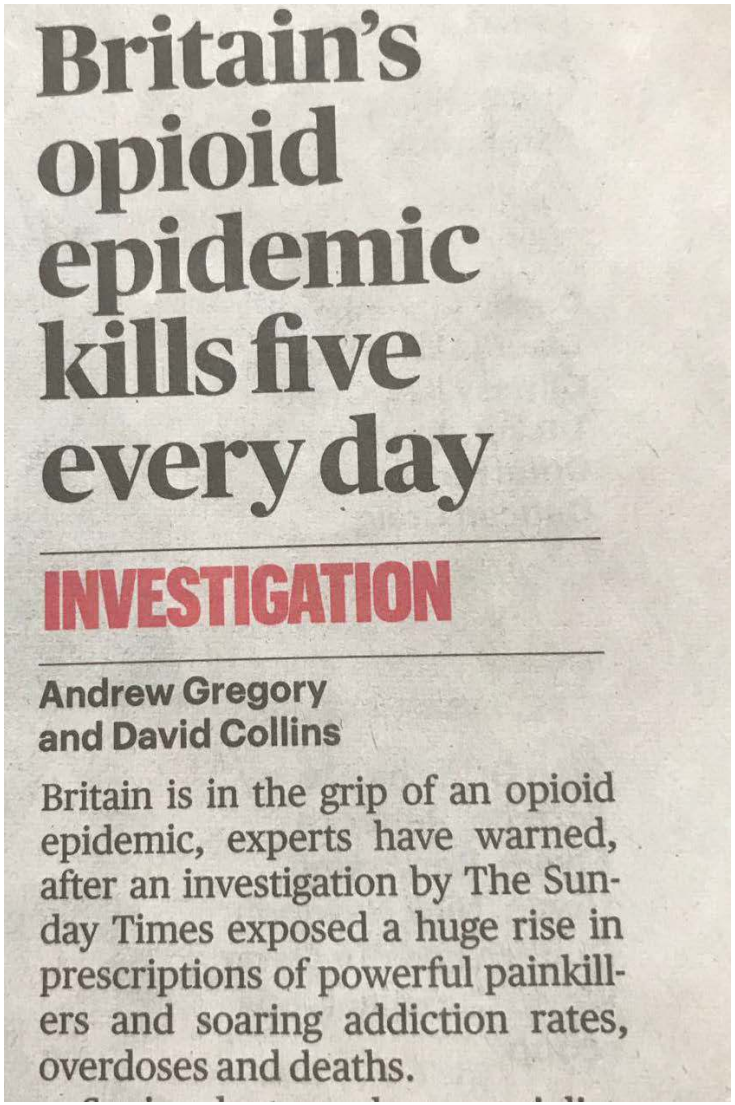
- There is no particular type of pain that is more suitable for or responsive to opioid treatment (Stannard 2018).

- Short term efficacy does not guarantee long-term efficacy (Opioids Aware 2015) .

Opioid adverse effects & risks

Nausea or vomiting	Endocrine dysfunction	Overdose (risk is dose dependent)
Itching	Immune system	Misuse:1.4-1.5
Feeling dizzy/sleepy/ confused	Opioid hyperalgesia	Addiction (dependency) 1.10-1.11
Chronic constipation	Falls and fractures	Co-prescriptions with hypnotics & CNS depressants including alcohol
Weight gain	Road traffic accidents	Serotonin syndrome
Difficulty in breathing at night/respiratory depression	Neonatal abstinence syndrome	Refractory tolerance, when treating acute or end of life pain

Feb 2019



Britain's opioid epidemic kills five every day

INVESTIGATION

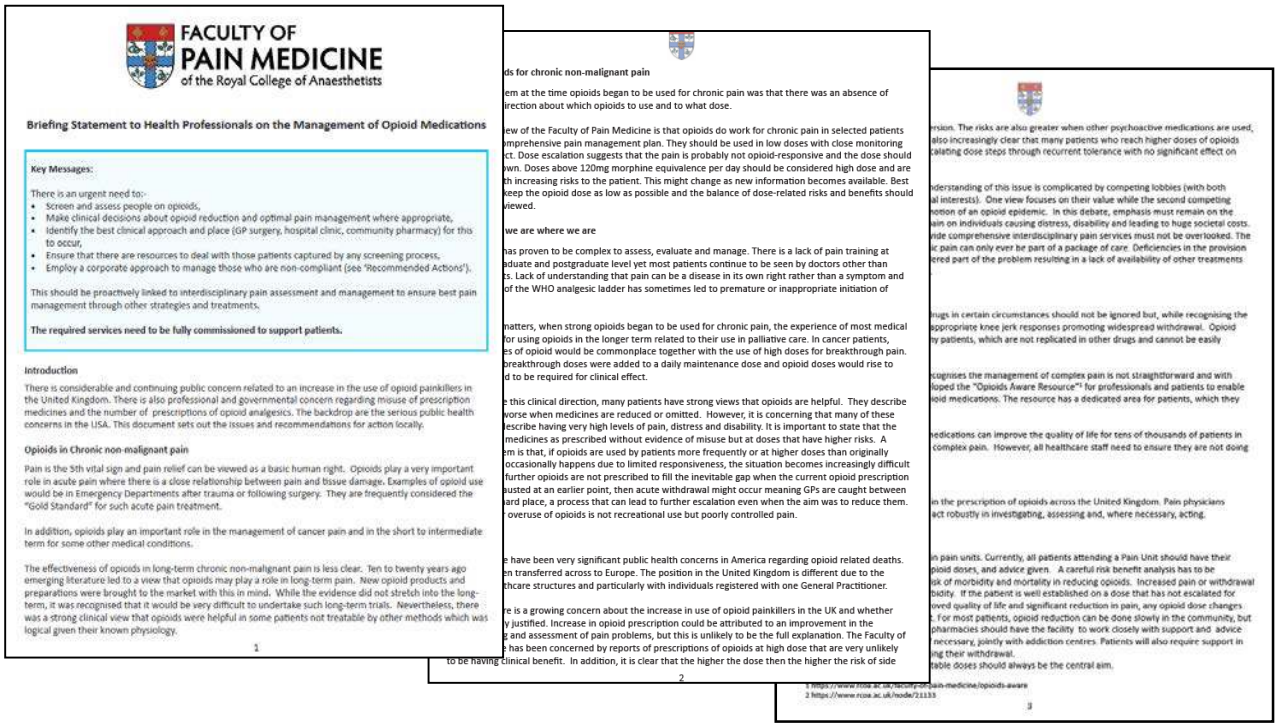
Andrew Gregory and David Collins

Britain is in the grip of an opioid epidemic, experts have warned, after an investigation by The Sunday Times exposed a huge rise in prescriptions of powerful painkillers and soaring addiction rates, overdoses and deaths.

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

November 2018

Briefing Statement to Health Professionals on the Management of Opioid Medications



FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists

Briefing Statement to Health Professionals on the Management of Opioid Medications

Key Messages:

There is an urgent need to:-

- Screen and assess people on opioids,
- Make clinical decisions about opioid reduction and optimal pain management where appropriate,
- Identify the best clinical approach and place (GP surgery, hospital clinic, community pharmacy) for this to occur,
- Ensure that there are resources to deal with those patients captured by any screening process,
- Employ a corporate approach to manage those who are non-compliant (see 'Recommended Actions').

This should be proactively linked to interdisciplinary pain assessment and management to ensure best pain management through other strategies and treatments.

The required services need to be fully commissioned to support patients.

Introduction

There is considerable and continuing public concern related to an increase in the use of opioid painkillers in the United Kingdom. There is also professional and governmental concern regarding misuse of prescription medicines and the number of prescriptions of opioid analgesics. The backdrop are the serious public health concerns in the USA. This document sets out the issues and recommendations for action locally.

Opioids in Chronic non-malignant pain

Pain is the 5th vital sign and pain relief can be viewed as a basic human right. Opioids play a very important role in acute pain where there is a close relationship between pain and tissue damage. Examples of opioid use would be in Emergency Departments after trauma or following surgery. They are frequently considered the "Gold Standard" for such acute pain treatment.

In addition, opioids play an important role in the management of cancer pain and in the short to intermediate term for some other medical conditions.

The effectiveness of opioids in long-term chronic non-malignant pain is less clear. Ten to twenty years ago emerging literature led to a view that opioids may play a role in long-term pain. New opioid products and preparations were brought to the market with this in mind. While the evidence did not stretch into the long-term, it was recognised that it would be very difficult to undertake such long-term trials. Nevertheless, there was a strong clinical view that opioids were helpful in some patients not treatable by other methods which was logical given their known physiology.

1

ds for chronic non-malignant pain

em at the time opioids began to be used for chronic pain was that there was an absence of irection about which opioids to use and to what dose.

iew of the Faculty of Pain Medicine is that opioids do work for chronic pain in selected patients mprehensive pain management plan. They should be used in low doses with close monitoring ct. Dose escalation suggests that the pain is probably not opioid-responsive and the dose should wn. Doses above 120mg morphine equivalence per day should be considered high dose and are h increasing risks to the patient. This might change as new information becomes available. Best keep the opioid dose as low as possible and the balance of dose-related risks and benefits should viewed.

we are where we are

has proven to be complex to assess, evaluate and manage. There is a lack of pain training at aduate and postgraduate level yet most patients continue to be seen by doctors other than ts. Lack of understanding that pain can be a disease in its own right rather than a symptom and of the WHO analgesic ladder has sometimes led to premature or inappropriate initiation of

matters, when strong opioids began to be used for chronic pain, the experience of most medical or using opioids in the longer term related to their use in palliative care. In cancer patients, es of opioid would be commonplace together with the use of high doses for breakthrough pain. breakthrough doses were added to a daily maintenance dose and opioid doses would rise to d to be required for clinical effect.

this clinical direction, many patients have strong views that opioids are helpful. They describe orse when medicines are reduced or omitted. However, it is concerning that many of these escribe having very high levels of pain, distress and disability. It is important to state that the medicines as prescribed without evidence of misuse but at doses that have higher risks. A m is that, if opioids are used by patients more frequently or at higher doses than originally occasionally happens due to limited responsiveness, the situation becomes increasingly difficult further opioids are not prescribed to fill the inevitable gap when the current opioid prescription usted at an earlier point, then acute withdrawal might occur meaning GPs are caught between ard place, a process that can lead to further escalation even when the aim was to reduce them. overuse of opioids is not recreational use but poorly controlled pain.

e have been very significant public health concerns in America regarding opioid related deaths. en transferred across to Europe. The position in the United Kingdom is different due to the thcare structures and particularly with individuals registered with one General Practitioner.

re is a growing concern about the increase in use of opioid painkillers in the UK and whether y justified. Increase in opioid prescription could be attributed to an improvement in the g and assessment of pain problems, but this is unlikely to be the full explanation. The Faculty of has been concerned by reports of prescriptions of opioids at high dose that are very unlikely to be having clinical benefit. In addition, it is clear that the higher the dose then the higher the risk of side

2

ersion. The risks are also greater when other psychoactive medications are used, also increasingly clear that many patients who reach higher doses of opioids calating dose steps through recurrent tolerance with no significant effect on

derstanding of this issue is complicated by competing lobbies (with both al interests). One view focuses on their value while the second competing otion of an opioid epidemic. In this debate, emphasis must remain on the ain on individuals causing distress, disability and leading to huge societal costs. ide comprehensive interdisciplinary pain services must not be overlooked. The ic pain can only ever be part of a package of care. Deficiencies in the provision ered part of the problem resulting in a lack of availability of other treatments

rugs in certain circumstances should not be ignored but, while recognising the appropriate knee jerk responses promoting widespread withdrawal. Opioid ny patients, which are not replicated in other drugs and cannot be easily

cognises the management of complex pain is not straightforward and with loped the "Opioids Aware Resource"[1] for professionals and patients to enable oid medications. The resource has a dedicated area for patients, which they

edications can improve the quality of life for tens of thousands of patients in complex pain. However, all healthcare staff need to ensure they are not doing

in the prescription of opioids across the United Kingdom. Pain physicians act robustly in investigating, assessing and, where necessary, acting.

in pain units. Currently, all patients attending a Pain Unit should have their pioid doses, and advice given. A careful risk benefit analysis has to be sk of morbidity and mortality in reducing opioids. Increased pain or withdrawal bidity. If the patient is well established on a dose that has not escalated for oved quality of life and significant reduction in pain, any opioid dose changes . For most patients, opioid reduction can be done slowly in the community, but pharmacies should have the facility to work closely with support and advice necessary, jointly with addiction centres. Patients will also require support in ng their withdrawal.
table doses should always be the central aim.

1 https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2 https://www.rcoa.ac.uk/node/21133

3

Deprescribing of inappropriate prescription opioids

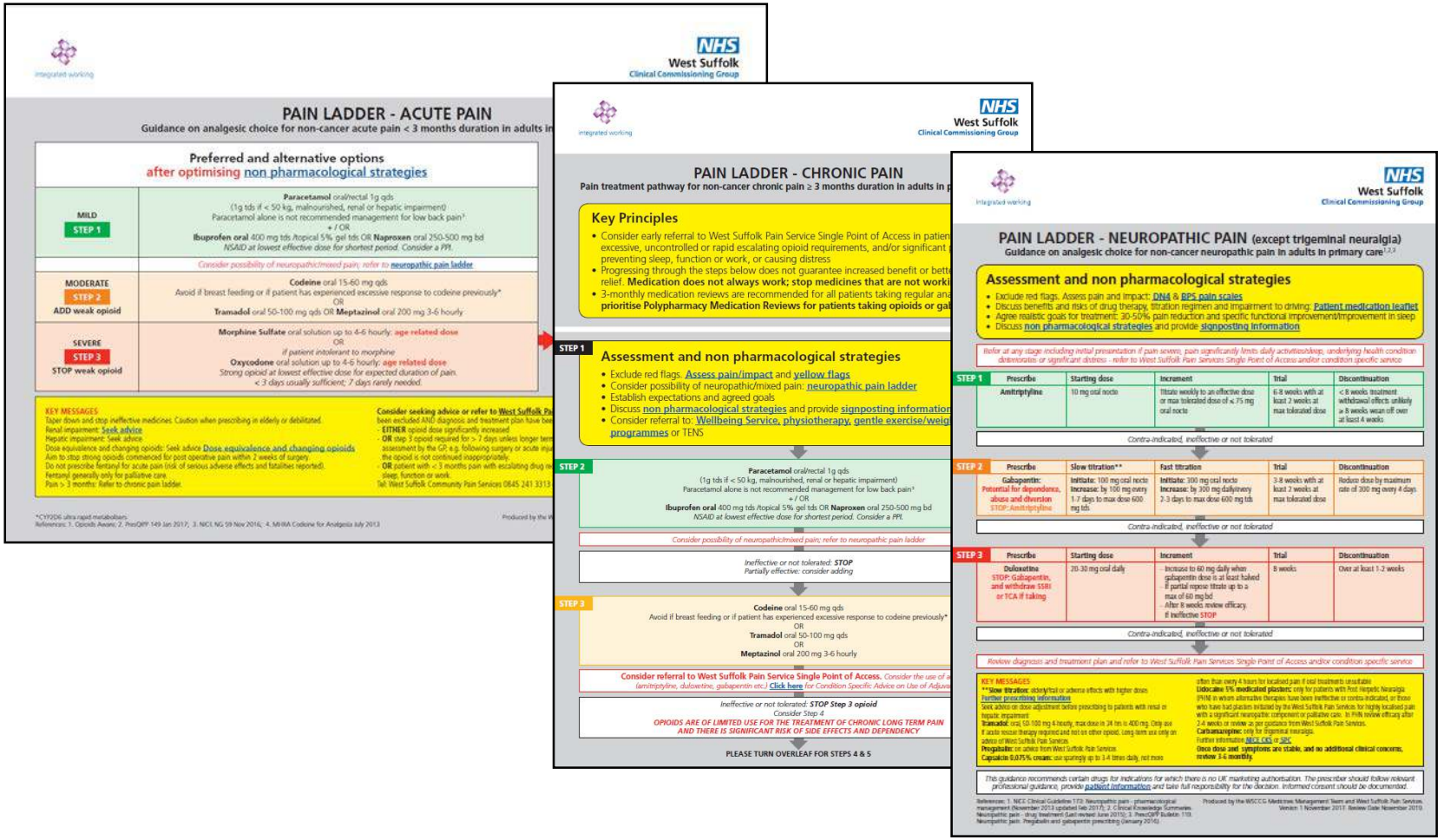
Patients urged to reduce use of opioids - but warned not to go cold turkey

Michael Steward michael.steward@archant.co.uk @MichaelReporter | 28 February, 2019 - 15:39

Dr David Egan, prescribing lead and clinical executive member at NHS Ipswich and East Suffolk CCG Picture: PAGEPIX

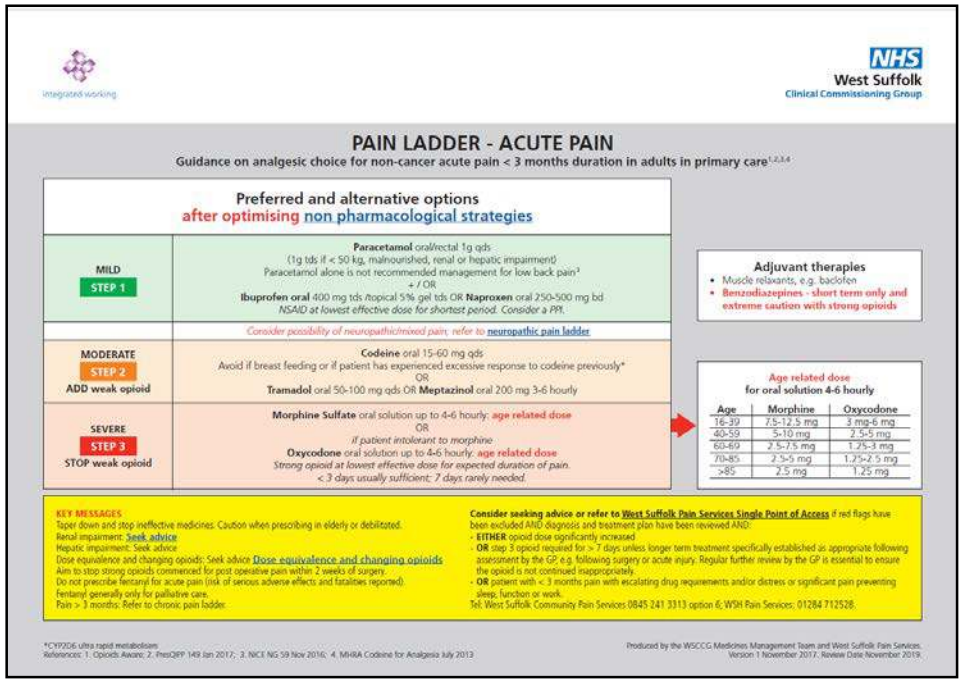
Prescribing GP Leads meetings in both the East and West have recently focused on reducing the risks associated with inappropriate prescribing of prescription opioids and gabapentinoids

WSCCG revised analgesic ladders



https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/

Acute Pain



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NHS West Suffolk Clinical Commissioning Group

PAIN LADDER - ACUTE PAIN

Guidance on analgesic choice for non-cancer acute pain < 3 months duration in adults in primary care[1,2,3,4]

Preferred and alternative options after optimising non pharmacological strategies

MILD — STEP 1

Paracetamol oral/rectal 1g qds
(1g tds if < 50 kg, malnourished, renal or hepatic impairment)
Paracetamol alone is not recommended management for low back pain[3]
+ / OR
Ibuprofen oral 400 mg tds /topical 5% gel tds OR **Naproxen** oral 250-500 mg bd
NSAID at lowest effective dose for shortest period. Consider a PPI.

Consider possibility of neuropathic/mixed pain, refer to **neuropathic pain ladder**

MODERATE — STEP 2 — ADD weak opioid

Codeine oral 15-60 mg qds
Avoid if breast feeding or if patient has experienced excessive response to codeine previously*
OR
Tramadol oral 50-100 mg qds OR **Meptazinol** oral 200 mg 3-6 hourly

SEVERE — STEP 3 — STOP weak opioid

Morphine Sulfate oral solution up to 4-6 hourly: **age related dose**
OR
If patient intolerant to morphine
Oxycodone oral solution up to 4-6 hourly: **age related dose**
Strong opioid at lowest effective dose for expected duration of pain.
< 3 days usually sufficient; 7 days rarely needed.

Adjuvant therapies
- Muscle relaxants, e.g. baclofen
- **Benzodiazepines - short term only and extreme caution with strong opioids**

Age related dose for oral solution 4-6 hourly

Age	Morphine	Oxycodone
16-39	7.5-12.5 mg	3 mg-6 mg
40-59	5-10 mg	2.5-5 mg
60-69	2.5-7.5 mg	1.25-3 mg
70-85	2.5-5 mg	1.25-2.5 mg
>85	2.5 mg	1.25 mg

KEY MESSAGES
Taper down and stop ineffective medicines. Caution when prescribing in elderly or debilitated.
Renal impairment: **Seek advice**
Hepatic impairment: Seek advice
Dose equivalence and changing opioids: Seek advice **Dose equivalence and changing opioids**
Aim to stop strong opioids commenced for post operative pain within 2 weeks of surgery.
Do not prescribe fentanyl for acute pain (risk of serious adverse effects and fatalities reported).
Fentanyl generally only for palliative care.
Pain > 3 months: Refer to chronic pain ladder.

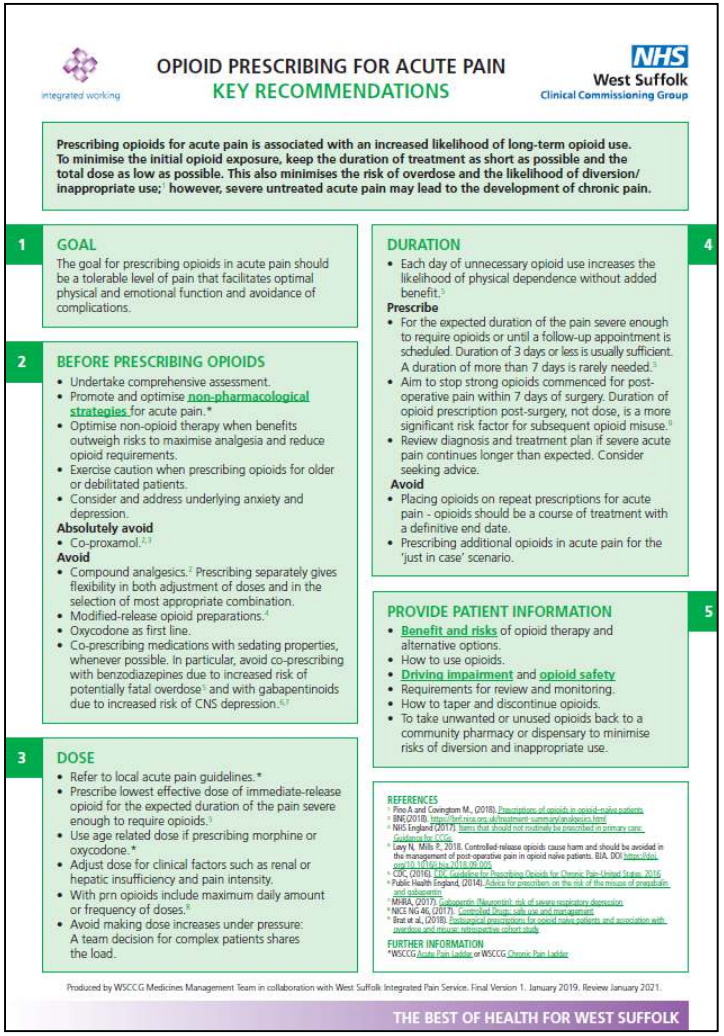
Consider seeking advice or refer to West Suffolk Pain Services Single Point of Access if red flags have been excluded AND diagnosis and treatment plan have been reviewed AND:
- **EITHER** opioid dose significantly increased
- **OR** step 3 opioid required for > 7 days unless longer term treatment specifically established as appropriate following assessment by the GP, e.g. following surgery or acute injury. Regular further review by the GP is essential to ensure the opioid is not continued inappropriately.
- **OR** patient with < 3 months pain with escalating drug requirements and/or distress or significant pain preventing sleep, function or work.

Tel: West Suffolk Community Pain Services 0845 241 3313 option 6; WSH Pain Services: 01284 712528.

*CYP2D6 ultra rapid metabolisers

References: 1. Opioids Aware; 2. PrescQIPP 149 Jan 2017; 3. NICE NG 59 Nov 2016; 4. MHRA Codeine for Analgesia July 2013

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services.
Version 1 November 2017. Review Date November 2019.



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OPIOID PRESCRIBING FOR ACUTE PAIN
KEY RECOMMENDATIONS

NHS West Suffolk Clinical Commissioning Group

Prescribing opioids for acute pain is associated with an increased likelihood of long-term opioid use. To minimise the initial opioid exposure, keep the duration of treatment as short as possible and the total dose as low as possible. This also minimises the risk of overdose and the likelihood of diversion/ inappropriate use;[1] however, severe untreated acute pain may lead to the development of chronic pain.

1 GOAL

The goal for prescribing opioids in acute pain should be a tolerable level of pain that facilitates optimal physical and emotional function and avoidance of complications.

2 BEFORE PRESCRIBING OPIOIDS

- Undertake comprehensive assessment.
- Promote and optimise **non-pharmacological strategies** for acute pain.*
- Optimise non-opioid therapy when benefits outweigh risks to maximise analgesia and reduce opioid requirements.
- Exercise caution when prescribing opioids for older or debilitated patients.
- Consider and address underlying anxiety and depression.

Absolutely avoid
- Co-proxamol.[2,3]

Avoid
- Compound analgesics.[2] Prescribing separately gives flexibility in both adjustment of doses and in the selection of most appropriate combination.
- Modified-release opioid preparations.[4]
- Oxycodone as first line.
- Co-prescribing medications with sedating properties, whenever possible. In particular, avoid co-prescribing with benzodiazepines due to increased risk of potentially fatal overdose[5] and with gabapentinoids due to increased risk of CNS depression.[6,7]

3 DOSE

- Refer to local acute pain guidelines.*
- Prescribe lowest effective dose of immediate-release opioid for the expected duration of the pain severe enough to require opioids.[3]
- Use age related dose if prescribing morphine or oxycodone.*
- Adjust dose for clinical factors such as renal or hepatic insufficiency and pain intensity.
- With prn opioids include maximum daily amount or frequency of doses.[8]
- Avoid making dose increases under pressure: A team decision for complex patients shares the load.

4 DURATION

- Each day of unnecessary opioid use increases the likelihood of physical dependence without added benefit.[3]

Prescribe
- For the expected duration of the pain severe enough to require opioids or until a follow-up appointment is scheduled. Duration of 3 days or less is usually sufficient. A duration of more than 7 days is rarely needed.[3]
- Aim to stop strong opioids commenced for post-operative pain within 7 days of surgery. Duration of opioid prescription post-surgery, not dose, is a more significant risk factor for subsequent opioid misuse.[9]
- Review diagnosis and treatment plan if severe acute pain continues longer than expected. Consider seeking advice.

Avoid
- Placing opioids on repeat prescriptions for acute pain - opioids should be a course of treatment with a definitive end date.
- Prescribing additional opioids in acute pain for the 'just in case' scenario.

5 PROVIDE PATIENT INFORMATION

- **Benefit and risks** of opioid therapy and alternative options.
- How to use opioids.
- **Driving impairment** and **opioid safety**
- Requirements for review and monitoring.
- How to taper and discontinue opioids.
- To take unwanted or unused opioids back to a community pharmacy or dispensary to minimise risks of diversion and inappropriate use.

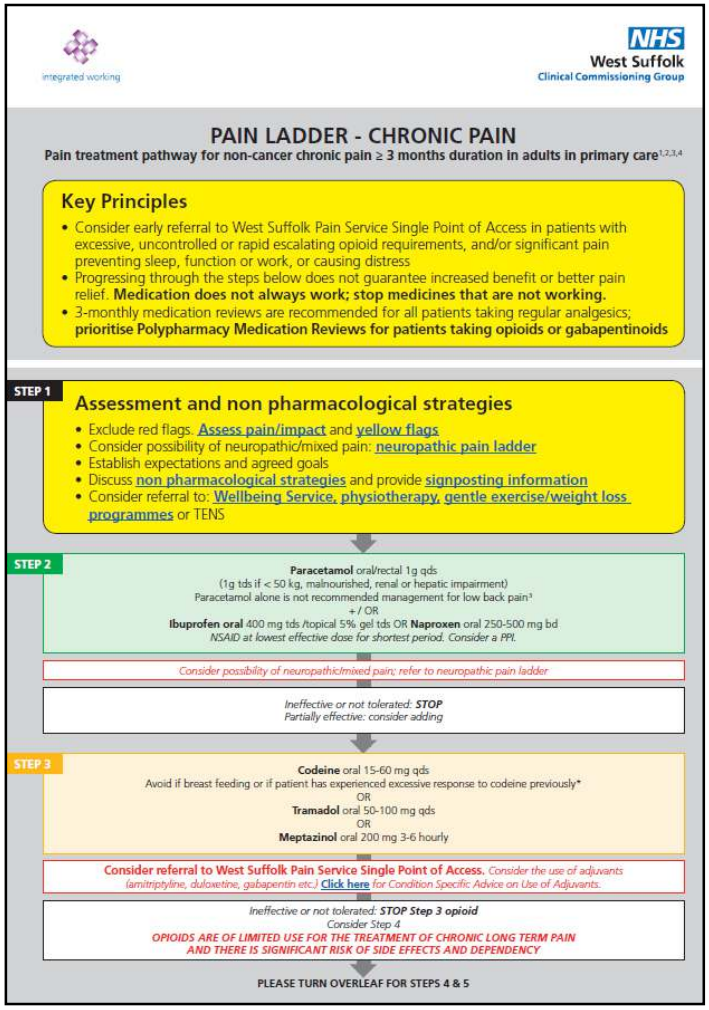
REFERENCES
1. Pino A and Covington M., (2018). Prescriptions of opioids in opioid-naive patients
2. BNF(2018). http://bnf.nice.org.uk/treatment-summary/analgesics.html
3. NHS England (2017). Items that should not routinely be prescribed in primary care: Guidance for CCGs
4. Levy N, Mills P., 2018. Controlled-release opioids cause harm and should be avoided in the management of post-operative pain in opioid naive patients. BJA. DOI https://doi.org/10.1016/j.bja.2018.09.005
5. CDC. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016
6. Public Health England, (2018). Advice for prescribers on the risk of the misuse of pregabalin and gabapentin
7. MHRA, (2017). Gabapentin (Neurontin): risk of severe respiratory depression
8. NICE NG 46, (2017). Controlled Drugs: safe use and management
9. Brat et al., (2018). Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study

FURTHER INFORMATION
*WSCCG Acute Pain Ladder or WSCCG Chronic Pain Ladder

Produced by WSCCG Medicines Management Team in collaboration with West Suffolk Integrated Pain Service. Final Version 1. January 2019. Review January 2021.

THE BEST OF HEALTH FOR WEST SUFFOLK

Chronic Pain



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PAIN LADDER - CHRONIC PAIN

Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care[1,2,3,4]

Key Principles

- Consider early referral to West Suffolk Pain Service Single Point of Access in patients with excessive, uncontrolled or rapid escalating opioid requirements, and/or significant pain preventing sleep, function or work, or causing distress
- Progressing through the steps below does not guarantee increased benefit or better pain relief. **Medication does not always work; stop medicines that are not working.**
- 3-monthly medication reviews are recommended for all patients taking regular analgesics; **prioritise Polypharmacy Medication Reviews for patients taking opioids or gabapentinoids**

STEP 1

Assessment and non pharmacological strategies

- Exclude red flags. Assess pain/impact and yellow flags
- Consider possibility of neuropathic/mixed pain: neuropathic pain ladder
- Establish expectations and agreed goals
- Discuss non pharmacological strategies and provide signposting information
- Consider referral to: Wellbeing Service, physiotherapy, gentle exercise/weight loss programmes or TENS

STEP 2

Paracetamol oral/rectal 1g qds
(1g tds if < 50 kg, malnourished, renal or hepatic impairment)
Paracetamol alone is not recommended management for low back pain[3]
+ / OR
Ibuprofen oral 400 mg tds /topical 5% gel tds OR **Naproxen** oral 250-500 mg bd
NSAID at lowest effective dose for shortest period. Consider a PPI.

Consider possibility of neuropathic/mixed pain; refer to neuropathic pain ladder

Ineffective or not tolerated: ***STOP***
Partially effective: consider adding

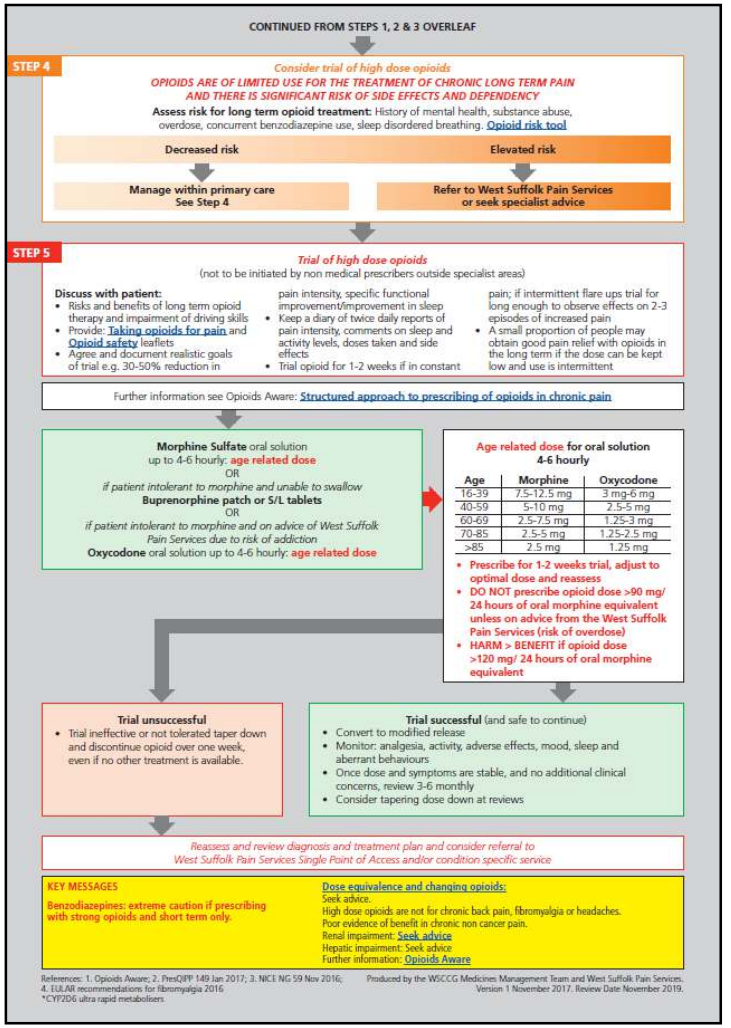
STEP 3

Codeine oral 15-60 mg qds
Avoid if breast feeding or if patient has experienced excessive response to codeine previously*
OR
Tramadol oral 50-100 mg qds
OR
Meptazinol oral 200 mg 3-6 hourly

Consider referral to West Suffolk Pain Service Single Point of Access. *Consider the use of adjuvants (amitriptyline, duloxetine, gabapentin etc.)* Click here *for Condition Specific Advice on Use of Adjuvants.*

Ineffective or not tolerated: ***STOP Step 3 opioid***
Consider Step 4
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

PLEASE TURN OVERLEAF FOR STEPS 4 & 5



CONTINUED FROM STEPS 1, 2 & 3 OVERLEAF

STEP 4

Consider trial of high dose opioids
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN AND THERE IS SIGNIFICANT RISK OF SIDE EFFECTS AND DEPENDENCY

Assess risk for long term opioid treatment: History of mental health, substance abuse, overdose, concurrent benzodiazepine use, sleep disordered breathing. Opioid risk tool

Decreased risk	Elevated risk
Manage within primary care See Step 4	Refer to West Suffolk Pain Services or seek specialist advice

STEP 5

Trial of high dose opioids
(not to be initiated by non medical prescribers outside specialist areas)

Discuss with patient:

- Risks and benefits of long term opioid therapy and impairment of driving skills
- Provide: Taking opioids for pain and Opioid safety leaflets
- Agree and document realistic goals of trial e.g. 30-50% reduction in pain intensity, specific functional improvement/improvement in sleep
- Keep a diary of twice daily reports of pain intensity, comments on sleep and activity levels, doses taken and side effects
- Trial opioid for 1-2 weeks if in constant pain; if intermittent flare ups trial for long enough to observe effects on 2-3 episodes of increased pain
- A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and use is intermittent

Further information see Opioids Aware: Structured approach to prescribing of opioids in chronic pain

Morphine Sulfate oral solution
up to 4-6 hourly: age related dose
OR
if patient intolerant to morphine and unable to swallow
Buprenorphine patch or S/L tablets
OR
if patient intolerant to morphine and on advice of West Suffolk Pain Services due to risk of addiction
Oxycodone oral solution up to 4-6 hourly: age related dose

Age related dose for oral solution 4-6 hourly

Age	Morphine	Oxycodone
16-39	7.5-12.5 mg	3 mg-6 mg
40-59	5-10 mg	2.5-5 mg
60-69	2.5-7.5 mg	1.25-3 mg
70-85	2.5-5 mg	1.25-2.5 mg
>85	2.5 mg	1.25 mg

- **Prescribe for 1-2 weeks trial, adjust to optimal dose and reassess**
- **DO NOT prescribe opioid dose >90 mg/ 24 hours of oral morphine equivalent unless on advice from the West Suffolk Pain Services (risk of overdose)**
- **HARM > BENEFIT if opioid dose >120 mg/ 24 hours of oral morphine equivalent**

Trial unsuccessful

- Trial ineffective or not tolerated taper down and discontinue opioid over one week, even if no other treatment is available.

Trial successful (and safe to continue)

- Convert to modified release
- Monitor: analgesia, activity, adverse effects, mood, sleep and aberrant behaviours
- Once dose and symptoms are stable, and no additional clinical concerns, review 3-6 monthly
- Consider tapering dose down at reviews

Reassess and review diagnosis and treatment plan and consider referral to West Suffolk Pain Services Single Point of Access and/or condition specific service

KEY MESSAGES

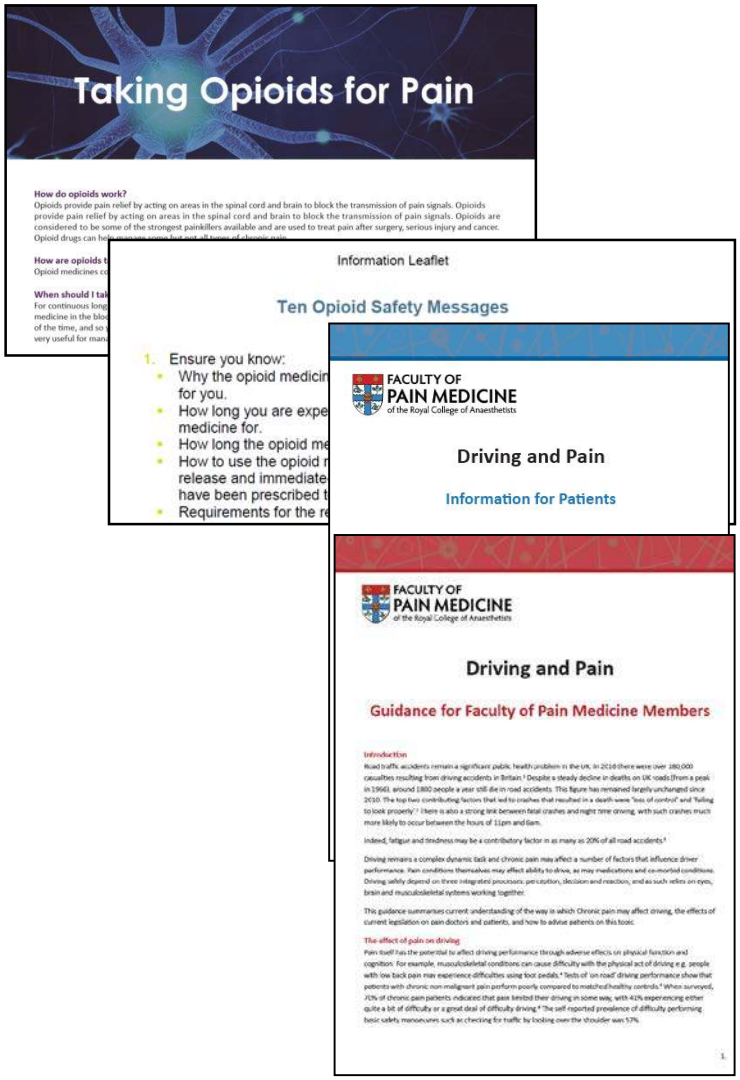
Benzodiazepines: extreme caution if prescribing with strong opioids and short term only.

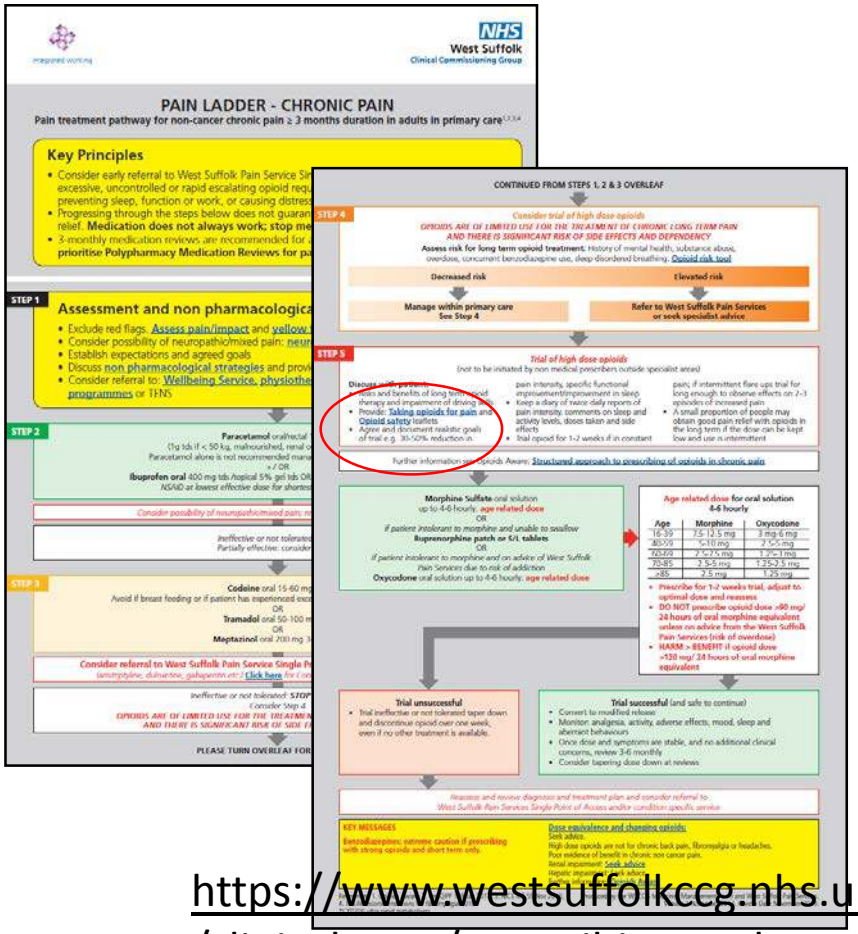
Dose equivalence and changing opioids:
Seek advice.
High dose opioids are not for chronic back pain, fibromyalgia or headaches.
Poor evidence of benefit in chronic non cancer pain.
Renal impairment: Seek advice
Hepatic impairment: Seek advice
Further information: Opioids Aware

References: 1. Opioids Aware; 2. PrescQIPP 149 Jan 2017; 3. NICE NG 59 Nov 2016; 4. EULAR recommendations for fibromyalgia 2016
*CYP2D6 ultra rapid metabolisers

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.

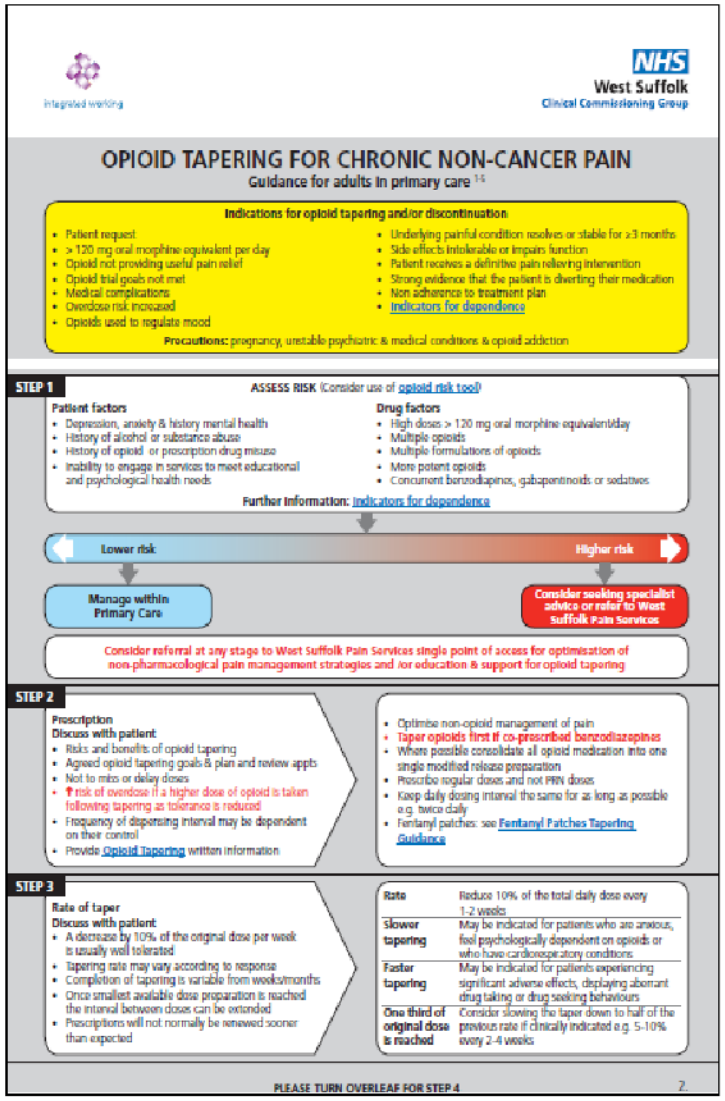
Prescription opioids: patient information





https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/

Opioid tapering resource pack



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NHS West Suffolk Clinical Commissioning Group

OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN

Guidance for adults in primary care [1-5]

Indications for opioid tapering and/or discontinuation:

- Patient request
- > 120 mg oral morphine equivalent per day
- Opioid not providing useful pain relief
- Opioid trial goals not met
- Medical complications
- Overdose risk increased
- Opioids used to regulate mood
- Underlying painful condition resolves or stable for ≥3 months
- Side effects intolerable or impairs function
- Patient receives a definitive pain relieving intervention
- Strong evidence that the patient is diverting their medication
- Non adherence to treatment plan
- Indicators for dependence

Precautions: pregnancy, unstable psychiatric & medical conditions & opioid addiction

STEP 1 — ASSESS RISK (Consider use of opioid risk tool)

Patient factors
- Depression, anxiety & history mental health
- History of alcohol or substance abuse
- History of opioid or prescription drug misuse
- Inability to engage in services to meet educational and psychological health needs

Drug factors
- High doses > 120 mg oral morphine equivalent/day
- Multiple opioids
- Multiple formulations of opioids
- More potent opioids
- Concurrent benzodiapinex, gabapentinoids or sedatives

Further information: Indicators for dependence

Lower risk → Manage within Primary Care

Higher risk → Consider seeking specialist advice or refer to West Suffolk Pain Services

Consider referral at any stage to West Suffolk Pain Services single point of access for optimisation of non-pharmacological pain management strategies and /or education & support for opioid tapering

STEP 2

Prescription
Discuss with patient:
- Risks and benefits of opioid tapering
- Agreed opioid tapering goals & plan and review appts
- Not to miss or delay doses
- ↑ risk of overdose if a higher dose of opioid is taken following tapering as tolerance is reduced
- Frequency of dispensing interval may be dependent on their control
- Provide Opioid Tapering written information

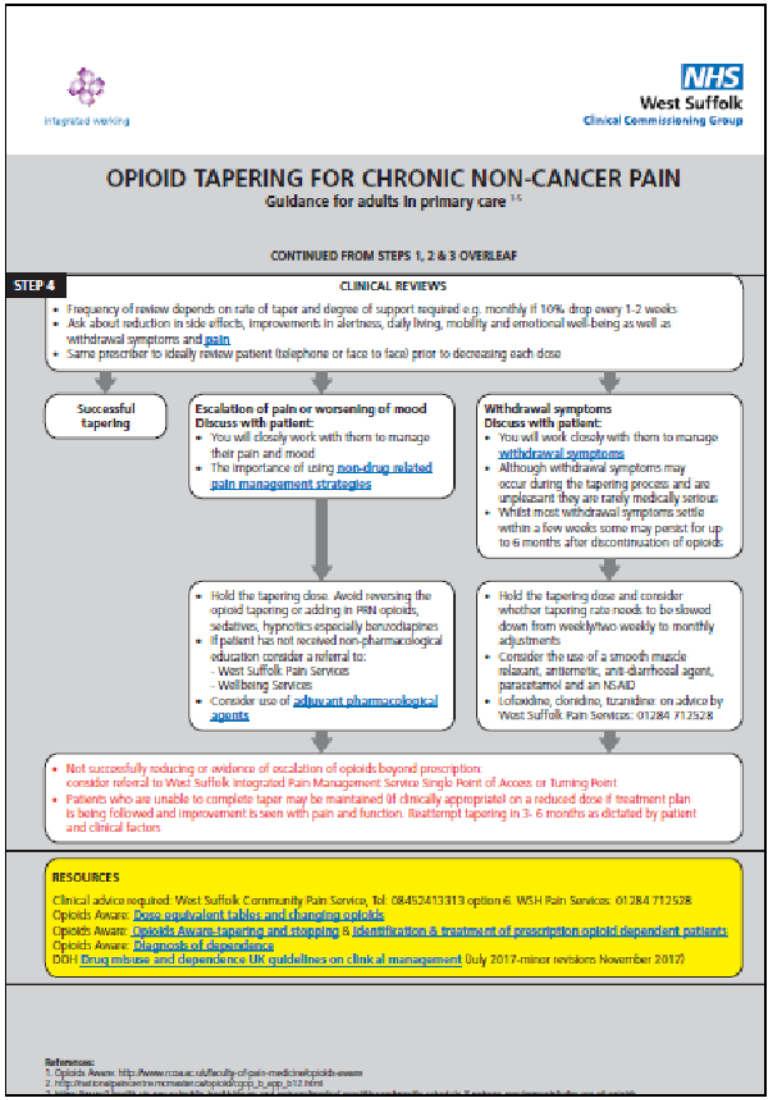
- Optimise non-opioid management of pain
- Taper opioids first if co-prescribed benzodiazepines
- Where possible consolidate all opioid medication into one single modified release preparation
- Prescribe regular doses and not PRN doses
- Keep daily dosing interval the same for as long as possible e.g. twice daily
- Fentanyl patches: see Fentanyl Patches Tapering Guidance

STEP 3

Rate of taper
Discuss with patient:
- A decrease by 10% of the original dose per week is usually well tolerated
- Tapering rate may vary according to response
- Completion of tapering is variable from weeks/months
- Once smallest available dose preparation is reached the interval between doses can be extended
- Prescriptions will not normally be renewed sooner than expected

Rate	Reduce 10% of the total daily dose every 1-2 weeks
Slower tapering	May be indicated for patients who are anxious, feel psychologically dependent on opioids or who have cardiorespiratory conditions
Faster tapering	May be indicated for patients experiencing significant adverse effects, displaying aberrant drug taking or drug seeking behaviours
One third of original dose is reached	Consider slowing the taper down to half of the previous rate if clinically indicated e.g. 5-10% every 2-4 weeks

PLEASE TURN OVERLEAF FOR STEP 4



Integrated working

NHS West Suffolk Clinical Commissioning Group

OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN

Guidance for adults in primary care [1-5]

CONTINUED FROM STEPS 1, 2 & 3 OVERLEAF

STEP 4 — CLINICAL REVIEWS

- Frequency of review depends on rate of taper and degree of support required e.g. monthly if 10% drop every 1-2 weeks
- Ask about reduction in side effects, improvements in alertness, daily living, mobility and emotional well-being as well as withdrawal symptoms and pain
- Same prescriber to ideally review patient (telephone or face to face) prior to decreasing each dose

Successful tapering

Escalation of pain or worsening of mood
Discuss with patient:
- You will closely work with them to manage their pain and mood
- The importance of using non-drug related pain management strategies

Withdrawal symptoms
Discuss with patient:
- You will work closely with them to manage withdrawal symptoms
- Although withdrawal symptoms may occur during the tapering process and are unpleasant they are rarely medically serious
- Whilst most withdrawal symptoms settle within a few weeks some may persist for up to 6 months after discontinuation of opioids

- Hold the tapering dose. Avoid reversing the opioid tapering or adding in PRN opioids, sedatives, hypnotics especially benzodiapines
- If patient has not received non-pharmacological education consider a referral to:
  - West Suffolk Pain Services
  - Wellbeing Services
- Consider use of adjuvant pharmacological agents

- Hold the tapering dose and consider whether tapering rate needs to be slowed down from weekly/two weekly to monthly adjustments
- Consider the use of a smooth muscle relaxant, antiemetic, anti-diarrhoeal agent, paracetamol and an NSAID
- Lofexidine, clonidine, tizanidine: on advice by West Suffolk Pain Services: 01284 713528

- Not successfully reducing or evidence of escalation of opioids beyond prescription consider referral to West Suffolk Integrated Pain Management Service Single Point of Access or Turning Point
- Patients who are unable to complete taper may be maintained (if clinically appropriate) on a reduced dose if treatment plan is being followed and improvement is seen with pain and function. Reattempt tapering in 3- 6 months as dictated by patient and clinical factors

RESOURCES

Clinical advice required: West Suffolk Community Pain Service, Tel: 08452413313 option 6. WSH Pain Services: 01284 713528
Opioids Aware: Dose equivalent tables and changing opioids
Opioids Aware: Opioids Aware-tapering and stopping & Identification & treatment of prescription opioid dependent patients
Opioids Aware: Diagnosis of dependence
DDH Drug misuse and dependence UK guidelines on clinical management (July 2017-minor revisions November 2017)

References:
1. Opioids Aware: http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
2. http://nationalpainstrm.mcmaster.ca/opioid/cpgn_h_app_b12.html

https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/

Supporting self-management

It is recommended that health care professionals (HCPs) should work with patients to develop:

1. Their understanding of chronic pain.
2. The value of self-management and non-pharmaceutical approaches.
3. Supportive strategies to enable people to access the tools, resources and support available to put these approaches in to practice.

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PAIN LADDER - CHRONIC PAIN

Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care[1,2,3,4]

Key Principles

- Consider early referral to West Suffolk Pain Service Single Point of Access in patients with excessive, uncontrolled or rapid escalating opioid requirements, and/or significant pain preventing sleep, function or work, or causing distress
- Progressing through the steps below does not guarantee increased benefit or better pain relief. **Medication does not always work; stop medicines that are not working.**
- 3-monthly medication reviews are recommended for all patients taking regular analgesics; **prioritise Polypharmacy Medication Reviews for patients taking opioids or gabapentinoids**

STEP 1

Assessment and non pharmacological strategies

- Exclude red flags. Assess pain/impact and yellow flags
- Consider possibility of neuropathic/mixed pain: neuropathic pain ladder
- Establish expectations and agreed goals
- Discuss non pharmacological strategies and provide signposting information
- Consider referral to: **Wellbeing Service, physiotherapy, gentle exercise/weight loss programmes** or TENS

Non-pharmacological hyperlinks

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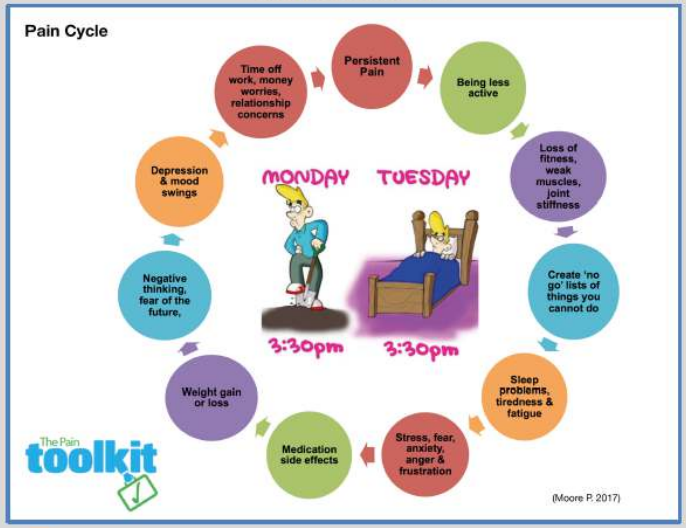
PERSISTENT PAIN: SUPPORTING SELF-MANAGEMENT
CLINICIAN'S QUICK GUIDE



Step 1	• Discuss with patient the impact of pain - see pain cycle above • Explain: persistent pain / reassure
Step 2	• Enable access: to resources/tools to increase knowledge & skills • Assess: patient's confidence to self-management
Step 3	• Self referral: One Life Suffolk, Physiotherapy, Wellbeing • Refer: West Suffolk Pain Services Single Point of Access

PLEASE TURN OVER FOR RESOURCES AND TOOLS

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.

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PERSISTENT PAIN: SUPPORTING SELF-MANAGEMENT
CLINICIAN'S QUICK GUIDE

STEP 1: Resources to explain persistent pain

Understanding pain and what to do about it in less than 5 minutes - You tube for patients.

Retrain Pain - Free course. 8 short modules which provide a scientific approach to understanding persistent pain through clear diagrammatic illustrations and key messages.

STEP 2: Resources/tools for patients

Signposting information - Local and national signposting information for patients with persistent pain.

Pain tool kit slide set – Power point presentation that introduces the pain tool kit.

Pain Toolkit - Simple guide that provides some handy tips and skills to help patients understand and manage their pain better. Available in hard copy, app, and an animated video. Website contains useful links for both patients and professionals.

Patient information leaflets - Wide selection of information leaflets to help patients to manage persistent pain. Leaflets can be printed via the Pain Service link.

Musculoskeletal self-help information - Online information and exercises developed by Allied Health Professionals Suffolk.

Understanding and managing long-term pain-information for patients - British Pain Society publication. Members of the public can request a free hard copy by contacting the BPS secretariat on 0207 269 7840 or info@britishpainsociety.org

Overcoming chronic pain - A self-help guide using cognitive behavioural techniques. This book on prescription can be borrowed from the library.

Resources for clinicians

Introducing the toolkit - You tube demonstrating how to introduce the pain toolkit during consultation.

Professional section on the Pain Toolkit website - On line information that explains how to use the persistent pain cycle with patients. Website also has extensive selection of resources for clinical practice.

Live Well with Pain - A website that provides support to clinicians to increase their confidence and skills in enabling people to live well through both self-management and effective medication use.
Launch date Nov 2017.

Produced by the WSCCG Medicines Management Team and West Suffolk Pain Services. Version 1 November 2017. Review Date November 2019.

Gabapentinoids


This Issue Views 791 | Citations 0 | Altmetric 34

Research Letter

November 27, 2018

Trends in First Gabapentin and Pregabalin Prescriptions in Primary Care in the United Kingdom, 1993-2017

François Montastruc, MD, PhD[1]; Simone Y. Loo, MSc[2]; Christel Renoux, MD, PhD[2]

> Author Affiliations

JAMA. 2018;320(20):2149-2151. doi:10.1001/jama.2018.12358

- The rate of patients newly treated with gabapentinoids has tripled from 2007 to 2017 in primary care.

By 2017

- 50% of gabapentinoid prescriptions were for an off-label indication.
- 20% of gabapentinoid prescriptions had a co-prescription for opioids.


Public Health England

NHS England

Advice for prescribers on the risk of the misuse of pregabalin and gabapentin

PHE 2014

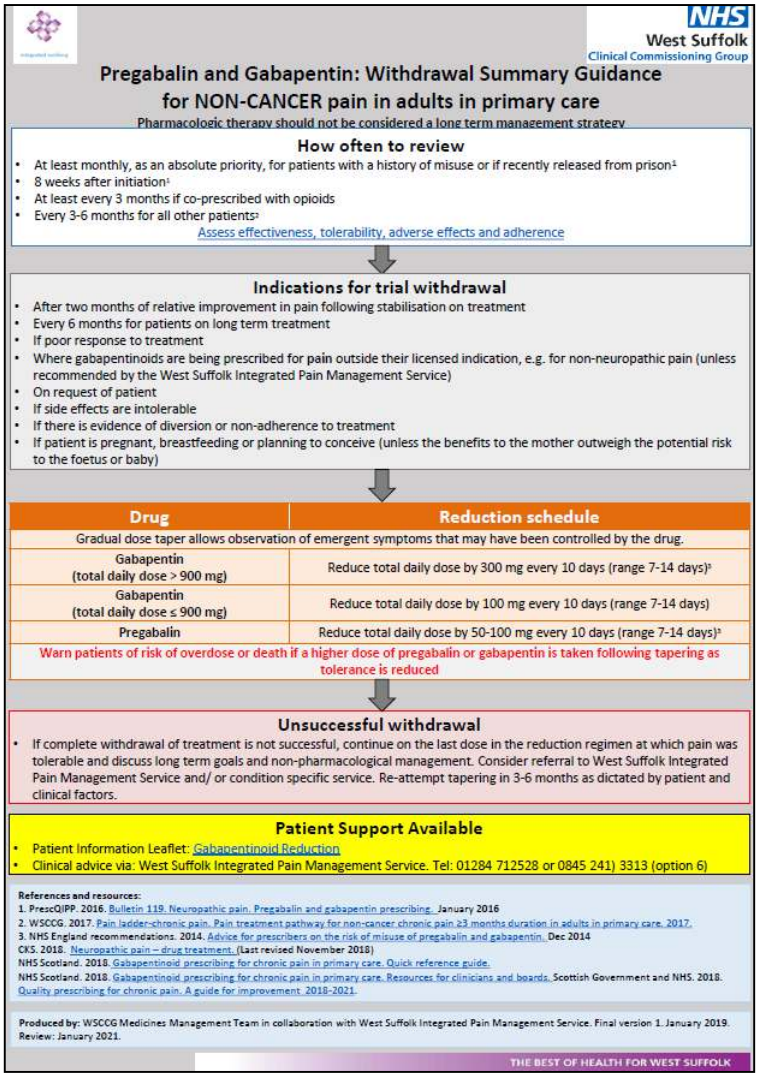

Advice for healthcare professionals:

- be aware of the risk of CNS depression, including severe respiratory depression, with gabapentin
- consider whether dose adjustments might be necessary in patients at higher risk of respiratory depression, including elderly people, patients with compromised respiratory function, respiratory or neurological disease, or renal impairment, and patients taking other CNS depressants
- report any suspected adverse reactions on a Yellow Card

MHRA 2017

Pregabalin and gabapentin withdrawal summary guidance

WSCCG 2019



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Pregabalin and Gabapentin: Withdrawal Summary Guidance for NON-CANCER pain in adults in primary care

Pharmacologic therapy should not be considered a long term management strategy

How often to review

- At least monthly, as an absolute priority, for patients with a history of misuse or if recently released from prison[1]
- 8 weeks after initiation[2]
- At least every 3 months if co-prescribed with opioids
- Every 3-6 months for all other patients[2]

Assess effectiveness, tolerability, adverse effects and adherence

Indications for trial withdrawal

- After two months of relative improvement in pain following stabilisation on treatment
- Every 6 months for patients on long term treatment
- If poor response to treatment
- Where gabapentinoids are being prescribed for pain outside their licensed indication, e.g. for non-neuropathic pain (unless recommended by the West Suffolk Integrated Pain Management Service)
- On request of patient
- If side effects are intolerable
- If there is evidence of diversion or non-adherence to treatment
- If patient is pregnant, breastfeeding or planning to conceive (unless the benefits to the mother outweigh the potential risk to the foetus or baby)

Drug	Reduction schedule
Gradual dose taper allows observation of emergent symptoms that may have been controlled by the drug.	
Gabapentin (total daily dose > 900 mg)	Reduce total daily dose by 300 mg every 10 days (range 7-14 days)[3]
Gabapentin (total daily dose ≤ 900 mg)	Reduce total daily dose by 100 mg every 10 days (range 7-14 days)
Pregabalin	Reduce total daily dose by 50-100 mg every 10 days (range 7-14 days)[3]

Warn patients of risk of overdose or death if a higher dose of pregabalin or gabapentin is taken following tapering as tolerance is reduced

Unsuccessful withdrawal

- If complete withdrawal of treatment is not successful, continue on the last dose in the reduction regimen at which pain was tolerable and discuss long term goals and non-pharmacological management. Consider referral to West Suffolk Integrated Pain Management Service and/ or condition specific service. Re-attempt tapering in 3-6 months as dictated by patient and clinical factors.

Patient Support Available

- Patient Information Leaflet: Gabapentinoid Reduction
- Clinical advice via: West Suffolk Integrated Pain Management Service. Tel: 01284 712528 or 0845 241) 3313 (option 6)

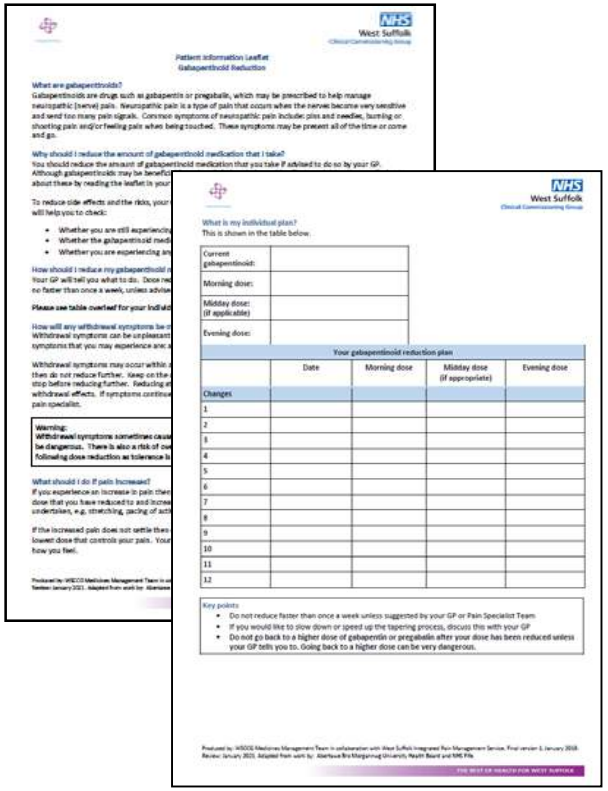
References and resources:

1. PrescQIPP. 2016. Bulletin 119. Neuropathic pain. Pregabalin and gabapentin prescribing. January 2016
2. WSCCG. 2017. Pain ladder-chronic pain. Pain treatment pathway for non-cancer chronic pain ≥3 months duration in adults in primary care. 2017.
3. NHS England recommendations. 2014. Advice for prescribers on the risk of misuse of pregabalin and gabapentin. Dec 2014

CKS. 2018. Neuropathic pain – drug treatment. (Last revised November 2018)
NHS Scotland. 2018. Gabapentinoid prescribing for chronic pain in primary care. Quick reference guide.
NHS Scotland. 2018. Gabapentinoid prescribing for chronic pain in primary care. Resources for clinicians and boards. Scottish Government and NHS. 2018.
Quality prescribing for chronic pain. A guide for improvement 2018-2021.

Produced by: WSCCG Medicines Management Team in collaboration with West Suffolk Integrated Pain Management Service. Final version 1. January 2019. Review: January 2021.

THE BEST OF HEALTH FOR WEST SUFFOLK



NHS West Suffolk Clinical Commissioning Group

Patient Information Leaflet
Gabapentinoid Reduction

What are gabapentinoids?

Why should I reduce the amount of gabapentinoid medication that I take?

What is my individual plan?
This is shown in the table below.

Current gabapentinoid:	
Morning dose:	
Midday dose: (if applicable)	
Evening dose:	

Your gabapentinoid reduction plan

	Date	Morning dose	Midday dose (if appropriate)	Evening dose
Changes				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

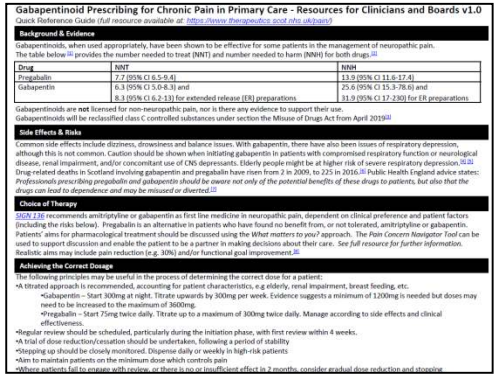
Warning:

What should I do if pain increases?

Key points
- Do not reduce faster than once a week unless suggested by your GP or Pain Specialist Team
- If you would like to slow down or speed up the tapering process, discuss this with your GP
- Do not go back to a higher dose of gabapentin or pregabalin after your dose has been reduced unless your GP tells you to. Going back to a higher dose can be very dangerous.

THE BEST OF HEALTH FOR WEST SUFFOLK

Gabapentinoids: Key resources and quick reference guide



Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0

Quick Reference Guide (*full resource available at: https://www.therapeutics.scot.nhs.uk/pain/*)

Background & Evidence

Gabapentinoids, when used appropriately, have been shown to be effective for some patients in the management of neuropathic pain.
The table below [1] provides the number needed to treat (NNT) and number needed to harm (NNH) for both drugs.[1]

Drug	NNT	NNH
Pregabalin	7.7 (95% CI 6.5-9.4)	13.9 (95% CI 11.6-17.4)
Gabapentin	6.3 (95% CI 5.0-8.3) and 8.3 (95% CI 6.2-13) for extended release (ER) preparations	25.6 (95% CI 15.3-78.6) and 31.9 (95% CI 17-230) for ER preparations

Gabapentinoids are **not** licensed for non-neuropathic pain, nor is there any evidence to support their use.
Gabapentinoids will be reclassified class C controlled substances under section the Misuse of Drugs Act from April 2019[2]

Side Effects & Risks

Common side effects include dizziness, drowsiness and balance issues. With gabapentin, there have also been issues of respiratory depression, although this is not common. Caution should be shown when initiating gabapentin in patients with compromised respiratory function or neurological disease, renal impairment, and/or concomitant use of CNS depressants. Elderly people might be at higher risk of severe respiratory depression.[3],[4]
Drug-related deaths in Scotland involving gabapentin and pregabalin have risen from 2 in 2009, to 225 in 2016.[5] Public Health England advice states: *Professionals prescribing pregabalin and gabapentin should be aware not only of the potential benefits of these drugs to patients, but also that the drugs can lead to dependence and may be misused or diverted.*[2]

Choice of Therapy

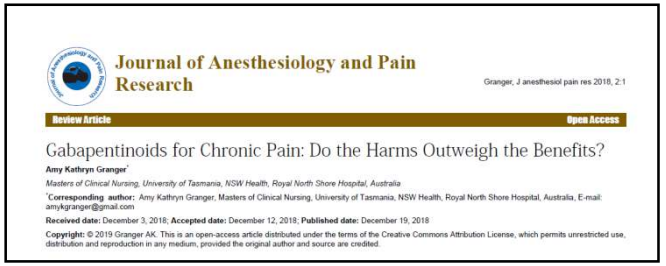
SIGN 136 recommends amitriptyline or gabapentin as first line medicine in neuropathic pain, dependent on clinical preference and patient factors (including the risks below). Pregabalin is an alternative in patients who have found no benefit from, or not tolerated, amitriptyline or gabapentin.
Patients' aims for pharmacological treatment should be discussed using the *What matters to you?* approach. The *Pain Concern Navigator Tool* can be used to support discussion and enable the patient to be a partner in making decisions about their care. *See full resource for further information.*
Realistic aims may include pain reduction (e.g. 30%) and/or functional goal improvement.[6]

Achieving the Correct Dosage

The following principles may be useful in the process of determining the correct dose for a patient:
- A titrated approach is recommended, accounting for patient characteristics, e.g elderly, renal impairment, breast feeding, etc.
  - Gabapentin – Start 300mg at night. Titrate upwards by 300mg per week. Evidence suggests a minimum of 1200mg is needed but doses may need to be increased to the maximum of 3600mg.
  - Pregabalin – Start 75mg twice daily. Titrate up to a maximum of 300mg twice daily. Manage according to side effects and clinical effectiveness.
- Regular review should be scheduled, particularly during the initiation phase, with first review within 4 weeks.
- A trial of dose reduction/cessation should be undertaken, following a period of stability
- Stepping up should be closely monitored. Dispense daily or weekly in high-risk patients
- Aim to maintain patients on the minimum dose which controls pain
- Where patients fail to engage with review, or there is no or insufficient effect in 2 months, consider gradual dose reduction and stopping

https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/11/Gabapentinoid-Quick-Reference-Guide-23112018-Final-v1.0.pdf

https://www.therapeutics.scot.nhs.uk/pain/



Journal of Anesthesiology and Pain Research

Granger, J anesthesiol pain res 2018, 2:1

Review Article | Open Access

Gabapentinoids for Chronic Pain: Do the Harms Outweigh the Benefits?

Amy Kathryn Granger*

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https://www.omicsonline.org/open-access/gabapentinoids-for-chronic-pain-do-the-harms-outweigh-the-benefits.pdf

Summary-a good prescription

(Stannad 2016,2018)

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Briefing Statement to Health Professionals on the Management of Opioid Medications

Key Messages:

There is an urgent need to:-

- Screen and assess people on opioids,
- Make clinical decisions about opioid reduction and optimal pain management where
- Identify the best clinical approach and place (GP surgery, hospital clinic, community
  to occur,
- Ensure that there are resources to deal with those patients captured by any screening
- Employ a corporate approach to manage those who are non-compliant (see 'Recomm

This should be proactively linked to interdisciplinary pain assessment and management to
management through other strategies and treatments.

The required services need to be fully commissioned to support patients.

Introduction

There is considerable and continuing public concern related to an increase in the use of opi
the United Kingdom. There is also professional and governmental concern regarding misuse
medicines and the number of prescriptions of opioid analgesics. The backdrop are the seric
concerns in the USA. This document sets out the issues and recommendations for action lo

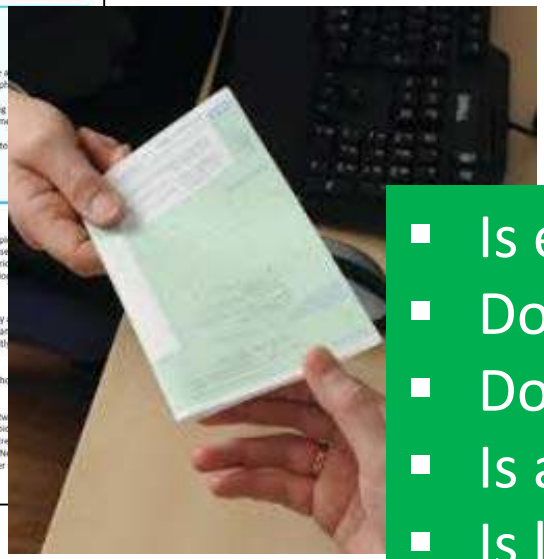
Opioids in Chronic non-malignant pain

Pain is the 5th vital sign and pain relief can be viewed as a basic human right. Opioids play
role in acute pain where there is a close relationship between pain and tissue damage. Exa
would be in Emergency Departments after trauma or following surgery. They are frequentl
"Gold Standard" for such acute pain treatment.

In addition, opioids play an important role in the management of cancer pain and in the sh
term for some other medical conditions.

The effectiveness of opioids in long-term chronic non-malignant pain is less clear. Ten to tw
emerging literature led to a view that opioids may play a role in long-term pain. New opioi
preparations were brought to the market with this in mind. While the evidence did not str
term, it was recognised that it would be very difficult to undertake such long-term trials. N
was a strong clinical view that opioids were helpful in some patients not treatable by other
logical given their known physiology.

1



- Is effective for the condition
- Does not harm the patient
- Does not harm anyone else
- Is acceptable to the patient
- Is legal and accurate

Key message

So giving a prescription for something that is likely not to work is a clinical 'big deal' in relation to iatrogenic harm

Stannard BJA 2018 120(6) 1148

Thank you

Further information and references on request

Christine.waters4@nhs.net

@Chrisrgwaters1

What do we know

Key changes to updated framework

(Hall 2019)

University of Reading

3. E-SYSTEMS AND REMOTE PRESCRIBING

- **4.9** Electronically generates or writes legible unambiguous and complete prescriptions which meet legal requirements
- **4.10** Effectively uses the systems necessary to prescribe medicines (e.g. medicine charts, electronic prescribing, decision support)

- **7.3** Identifies the potential risks associated with prescribing via remote media (telephone, email or through a third party) and takes steps to minimise them

Key resources to support remote prescribing (Hall 2019)

University of Reading

3. RESOURCES

- What practice standards exist to support remote prescribing?
  - Standards of proficiency for nurse and midwife prescribers
    - Standard 20
  - GMC guidance
    - Good practice in prescribing and managing medicines and devices
    - Paragraph 60

Context: a brief history

Picton ? 2017

ROYAL PHARMACEUTICAL SOCIETY

•Section Title

Context: a brief history

- Developed to support the introduction of non-medical prescribing.
- Developed before competency frameworks became commonly used in the NHS. Extensive empirical research.
- Individual frameworks for nurses and midwives, pharmacists, optometrists and allied health professionals.
- Used extensively in practice to underpin curricula development, as part of approved education programmes and to facilitate continuing professional development.

Context: a brief history

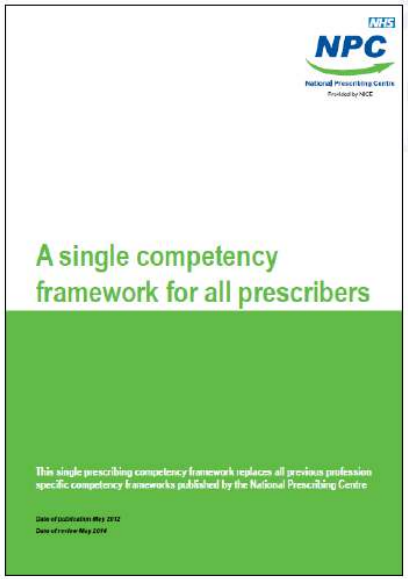
Picton ? 2017

ROYAL PHARMACEUTICAL SOCIETY

•Section Title

Context: a brief history

- Cumulative development experience and practical application indicated that, regardless of professional background, there is a common set of prescribing competencies.
- A single competency framework for all prescribers was published in May 2012 (consolidated the profession specific frameworks then updated with input from doctors and dentists).



Using the framework for service improvement and revalidation

- *Nfrom standrads*
- *Edcuaytopn revalidation*