



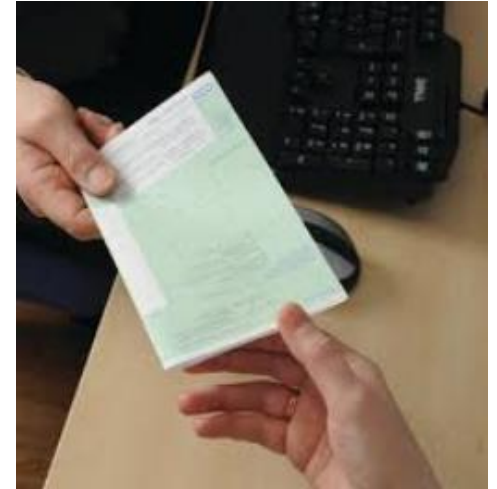
## Reducing the risks with prescription opioids

Christine Waters, RGN, MSc, BSc(Hons), INMP  
Lead CNS Professional Development,  
July 2019

# *Outline*

## **Prescription opioids**

- Background information
- What can an NMP do to reduce risks?
- Keeping up to date (CPD resources)



# USA: Opioid misuse epidemic



thebmj

BMJ 2017;359:j4792 doi: 10.1136/bmj.j4792 (Published 2017 October 19) Page 1 of 2

Check for updates

## EDITORIALS

### Overprescribing is major contributor to opioid crisis

Surgeons in particular must change their behaviour

M  
V

BMJ 2017;359:j4828 doi: 10.1136/bmj.j4828 (Published 2017 October 19) Page 1 of 1

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## EDITOR'S CHOICE

### What we must learn from the US opioid epidemic

Fiona Godlee *editor in chief*

The BMJ

CNN politics 45 CONGRESS SECURITY THE NINE TRUMP/AMERICA STATE

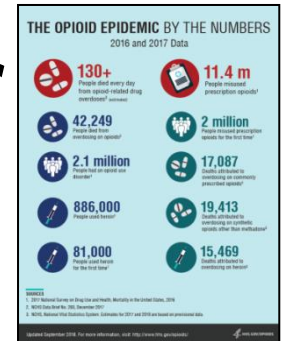
And speaking with reporters on the South Lawn of the White House on Wednesday, Trump said he would have a "very big meeting on opioids" on Thursday and will be declaring the opioid epidemic a national emergency "in the very near future."

### Public health emergency vs. national emergency

Related Article: House panel threatens to subpoena DEA over pill dumping in West Virginia

The primary difference between the two designations is access to funding.

# 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)

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## 'Unnecessary' painkillers could leave thousands addicted, doctors warn

Prescriptions for powerful opioid painkillers have doubled from 12m to 24m in past decade, NHS says

## Accidental addiction to painkillers 'a public health crisis', says charity

As the number of dependent patients grows, the lack of support for recovery is a major concern



Twelve million more pills are being prescribed

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### NHS accused of fuelling rise in opioid addiction

By David Rhodes  
BBC News

© 15 March 2018

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### Concerns raised as opioid prescriptions rise across UK

[Home](#) [News](#) [Concerns raised as opioid prescriptions rise across UK](#)

[PUBLISHED 20 DEC 2018](#)

[HEALTH](#) [RESEARCH](#) [SOCIETY](#)

[SHARE THIS](#) [RESEARCHERS recommend greater action to protect patients from prescriptions of opioids for treating chronic pain](#)

## GPs prescribe more opioid drugs for pain in poorer areas of England

Study finds nine areas in the north among top 10 highest prescribers in the country



## 'That's a scary moment': how that first prescription in hospital fuelled an opioid epidemic

By Kate Aubusson  
May 1, 2019 — 2:03pm



Up to one in 10 surgery patients who get hooked on opioids had never used the drugs before they were prescribed the medication after their operation, world-leading pain experts say.

[f](#) [t](#) [e](#) [A](#) [A](#)

They warned the potent painkillers themselves can switch on pain pathways in some patients, locking them in a vicious cycle: the more opioids they take, the worse they feel.

[9](#) [View all comments](#)



## GPs 'dished out opioid tablets over internet'

An addicted patient was given 1,600 pills, an inquiry has heard

## New prescription rules for GPs to curb UK's opioid epidemic

The health watchdog is to act after The Sunday Times exposed a surge in the use of addictive painkillers linked to five deaths a day



The health watchdog NICE will develop guidelines on safe opioid prescribing

The National Institute for Health and Care Excellence (NICE), the official health watchdog, is to develop guidelines for GPs on prescribing opioids and how to ease patients off the powerful painkillers.

# *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




# *What the public is being told*

*Sunday Times 2019*

- UK is hurtling towards a US style crisis
- Five people are dying every day from opioid overdoses
- Deaths up by 41% in a decade to approx 2000 a year
- The number of people hospitalised due to opioids has jumped to more than 11.500 a year

## Opioid prescribing trends and geographical variation in England, 1998–2018: a retrospective database study

[Helen J Curtis, DPhil](#) • [Richard Croker, MSc](#) • [Alex J Walker, PhD](#) • [Georgia C Richards, BSc](#) • [Jane Quinlan, FFPMRCA](#) •

[Ben Goldacre, MRCPsych](#)  

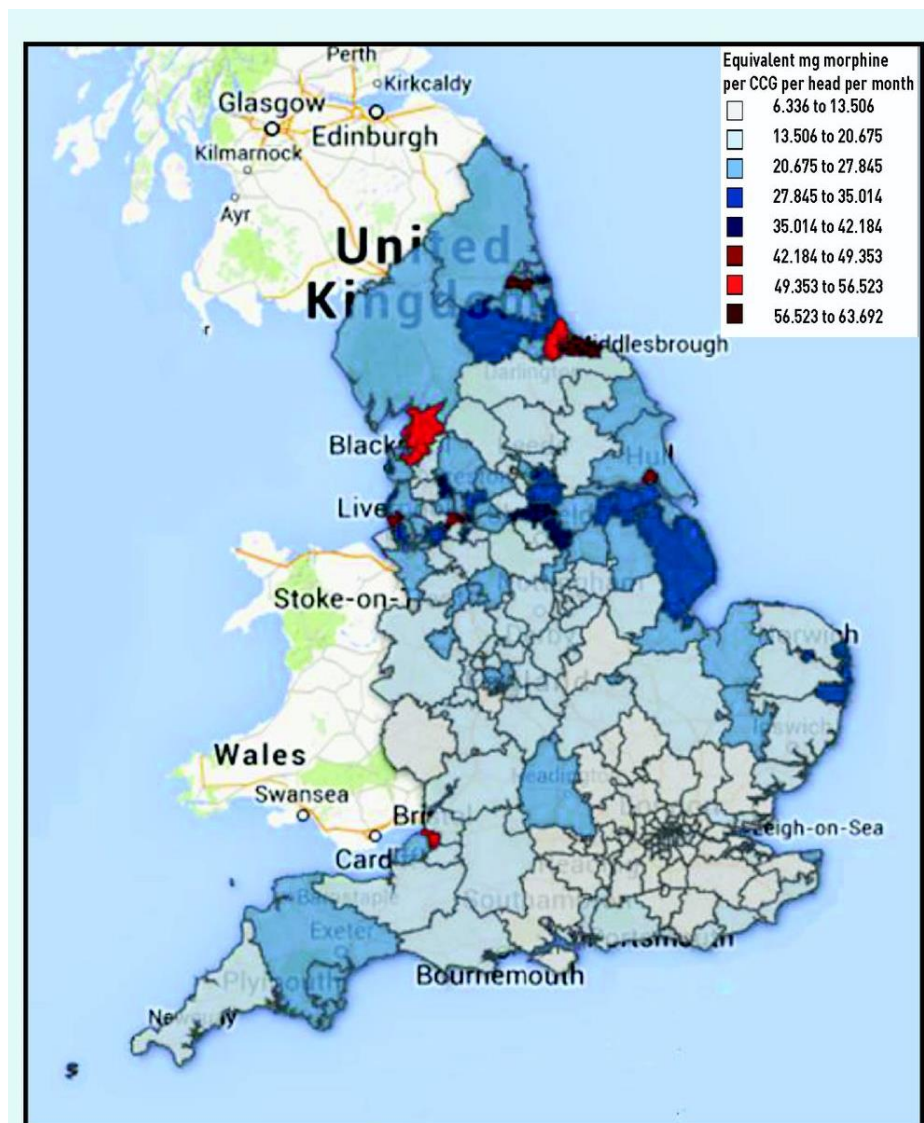
Published: December 20, 2018 • DOI: [https://doi.org/10.1016/S2215-0366\(18\)30471-1](https://doi.org/10.1016/S2215-0366(18)30471-1) •



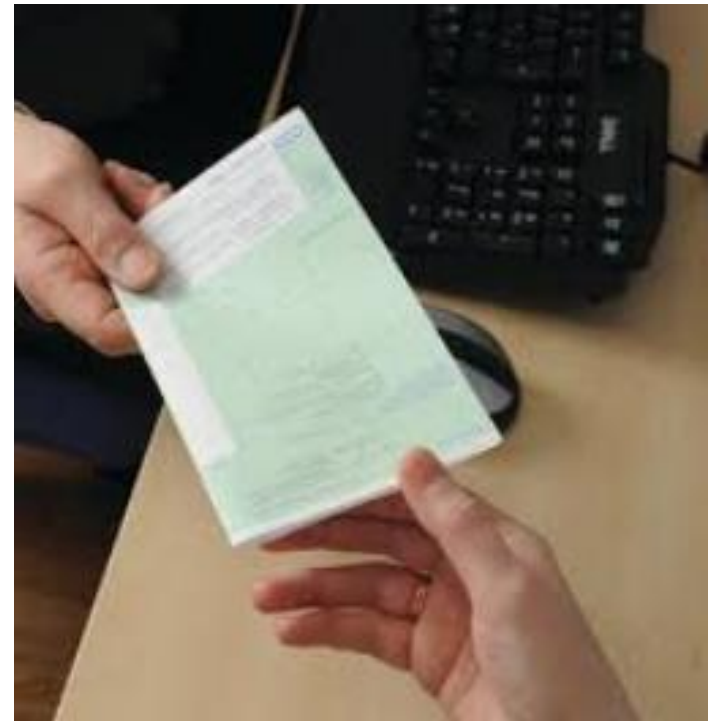
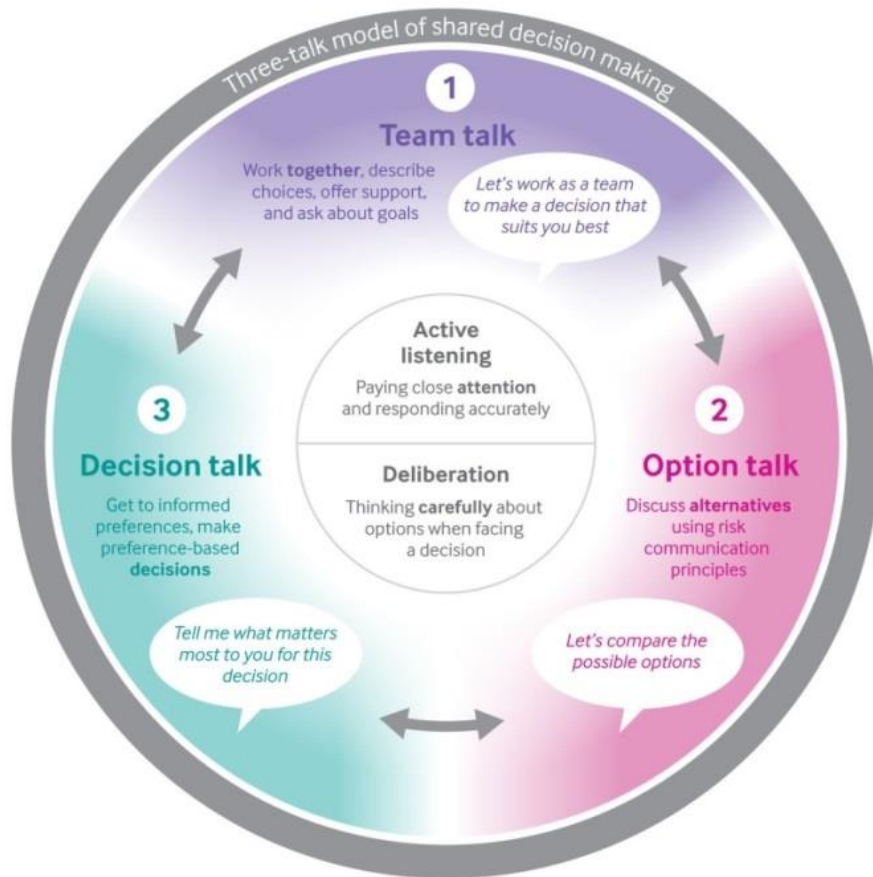
- Opioid prescriptions **increased by 34%** in England between 1998 and 2016.
- After correcting for total oral morphine equivalency, the **increase was 127%** (from 190 000 mg to 431 000 mg per 1000 population).
- There was a **decline** in prescriptions from 2016 to 2017.
- Greater high-dose prescribing rates was associated with larger practice list **size, ruralness, and deprivation**.
- The CCG group to which a practice belongs accounted for **11.7%** of the variation in high-dose prescribing.
- A publicly available interactive online tool, [OpenPrescribing.net](#), has been developed which displays all primary care opioid prescribing data in England down to the individual practice level.



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



# Prescription opioids: effectiveness versus harm



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

# *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 ).
- **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).
- Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term (Opioids Aware )
- Short term efficacy does not guarantee long-term efficacy (Opioids Aware) .
- There is no particular type of pain that is more suitable for or responsive to opioid treatment (Stannard 2018).

# *Opioid adverse effects & risks*

Nausea or vomiting	Endocrine dysfunction	Overdose (risk is dose dependent and)
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	<b>Respiratory depression</b> Co-prescriptions with hypnotics & CNS depressants alcohol or those with obstructive sleep apnoea
Weight gain	Road traffic accidents	Serotonin syndrome
Difficulty in breathing at night	Neonatal abstinence syndrome	Refractory tolerance, when treating acute or end of life pain

# National and local priority

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## Prescribed medicines that may cause dependence or withdrawal

A review of the evidence on the scale and nature of problems with some prescription medicines and how they can be prevented and treated.

Published 31 January 2018  
From: [Public Health England](#) and [Steve Brine MP](#)

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Press release

## Opioid Expert Working Group meets at MHRA

An Expert Working Group (EWG) of the UK's Commission on Human Medicines (CHM) met yesterday at the Medicines and Healthcare products Regulatory Agency (MHRA) to begin the review of the benefits and risks of opioid medicines, including dependence and addiction.

Published 13 February 2019  
From: [Medicines and Healthcare products Regulatory Agency](#)

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

Michael Steward [michael.steward@archant.co.uk](mailto: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

# Safer opioid prescribing

**NICE** National Institute for Health and Care Excellence

NICE Pathways **NICE Guidance** Standards and indicators Evidence search

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## Controlled drugs: safe use and management

NICE guideline [NG46] Published date: April 2016

**NICE** National Institute for Health and Care Excellence

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Home > NICE Guidance > Health and social care delivery > Medicines management > Medicines management: general and other

## Medicines optimisation in chronic pain

Key therapeutic topic [KTT21] Published date: January 2017 Last updated: March 2019

**PrescQIPP**  
Community Interest Company

### Reducing opioid prescribing in chronic pain

This bulletin discusses the processes and resources available to support opioid reduction (including discussion of advice from The Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM) and The US Centers for Disease Control and Prevention (CDC)); supporting resources include an audit, searches and tapering schedules. This bulletin should be used in conjunction with bulletin 149 on non-neuropathic pain, which includes further resources (e.g. patient information leaflet and patient opioid agreement letter).  
<https://www.prescqipp.info/resources/category/149-non-neuropathic-pain>

#### Recommendations

- There is little evidence that opioids are helpful for long term 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, but it is difficult to identify these people at the start of treatment.<sup>1</sup>
- Patients who do not achieve useful pain relief from opioids within 2-4 weeks are unlikely to gain benefit in the long term.<sup>2</sup>
- The risk of harm increases above 120mg oral morphine daily or equivalent. Above this dose the risk of harm and mortality increases substantially but there is no increased benefit.<sup>1,2</sup>
- There needs to be an agreed outcome of opioid reduction, with an explanation of the benefits of stopping an opioid.<sup>2</sup>
- If pain has not been reduced by at least 30% (or other pre-agreed objective), then opioids should be considered as not effective and discontinued, even if no other treatment is available.<sup>1,2</sup>
- Switching from one opioid to another should only be recommended or supervised by a healthcare practitioner with adequate competence and sufficient experience. If uncertain, ask for advice from a more experienced practitioner. Opioid rotation or switching may be considered if a patient obtains pain relief with one opioid and is suffering severe adverse effects.<sup>2</sup>
- Conversion factors are an approximate guide only because comprehensive data are lacking and there is significant inter-individual variation. An individualised approach is necessary.<sup>2</sup>
- 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.<sup>1</sup>
- Patients and carers should be involved in decision making, with plans made for follow up.<sup>2</sup>
- Total daily opioid dose should be reduced gradually when patients have been prescribed a strong opioid for longer than two weeks.<sup>2</sup>
- The total daily opioid dose can be reduced by 10% of the original dose weekly or every two weeks.<sup>2</sup>
- Whilst reducing the opioid, the patient needs to be monitored for pain, level of function, and signs of withdrawal.<sup>2</sup>
- Recognise patients with drug seeking behaviour (see appendix 2). For patients with drug seeking behaviour, both opioid dependent and non-opioid dependent (e.g. pregabalin and gabapentin); refer to specialist support for assessment and support (i.e. addiction services, in line with local commissioning policies). Ensure multi-disciplinary support.<sup>2</sup>

This document is for use within the NHS and is not for commercial or marketing purposes 1 of 12

# Opioids Aware

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  - > Contact us

## Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain



FPM in partnership with Public Health England

*Please note that we are in the process of updating the Opioids Aware resource so at times links or pages may not be working. If a page you require is not working it should be up and running again soon. If urgent please email [contact@fpm.ac.uk](mailto:contact@fpm.ac.uk)*

Good practice in prescribing opioid medicines for pain should reflect fundamental principles in prescribing generally. The decision to prescribe is underpinned by applying best professional practice; understanding the condition, the patient and their context and understanding the clinical use of the drug. Initiating, tapering or stopping opioid medicines should be managed in agreement with the patient and all members of their healthcare team. This resource, developed by UK healthcare professionals and policymakers, provides the information to support a safe and effective prescribing decision.

1. Opioids are very good analgesics for acute pain and for pain at the end of life 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 especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.
4. If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.
5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

### Resource at a Glance

- > [A sitemap of the Opioids Aware Resource.](#)

### Quick Links

- > [Pain assessment](#)
- > [The opioid trial](#)
- > [Dose equivalence](#)
- > [Tapering and stopping](#)
- > [Oxford Analgesic League Table](#)

### What's New?

- > [Opioids and driving](#)

1. Opioids are very good analgesics for acute pain and for pain at end of life but there is little evidence that they are helpful for long-term pain.
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5. Chronic pain is complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.



# Dose equivalence charts



integrated working



West Suffolk  
Clinical Commissioning Group

## OPIOID EQUIVALENCE, RISKS AND RECOMMENDATIONS<sup>1-3</sup>

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  $\geq 65$ , 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  $\geq 120$  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  $\geq 100$  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	<input type="text"/>	mg
Codeine Oral	<input type="text"/>	mg
Dihydrocodeine Oral	<input type="text"/>	mg
Oxycodone Oral	<input type="text"/>	mg
Tramadol Oral	<input type="text"/>	mg
Hydromorphone Oral	<input type="text"/>	mg
Tapentadol Oral	<input type="text"/>	mg
Methadone Oral	<input type="text"/>	mg

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Fentanyl SC	<input type="text"/>	mcg
Diamorphine SC	<input type="text"/>	mg
Alfentanil SC	<input type="text"/>	mcg
Hydromorphone SC	<input type="text"/>	mg
Oxycodone SC	<input type="text"/>	mg

---

Morphine IV	<input type="text"/>	mg
Fentanyl IV	<input type="text"/>	mcg

---

Fentanyl Patch	<input type="text"/>	mcg/h
Buprenorphine Patch	<input type="text"/>	mcg/h

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Morphine Epidural	<input type="text"/>	mg
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Morphine Intrathecal	<input type="text"/>	mcg
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**Chronic Pain Education Group**

- Dr Colin Rae, Lead for MCN Chronic Pain
- Dr Moutaz Burwais, Chair, Education Subgroup
- Ms Camilla Young, MCN Coordinator
- Ms Lyn Watson, Nurse Representative, Education Subgroup
- Ms Lorna Sempell, Physio Representative, Education Subgroup
- Ms Catriona Clareburt, Pharmacy Representative, Education Subgroup
- TBA, Patient Representative

Website and Info © 2019 CPEG Design JET5 Ltd. cms

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

# ***Prescribing/deprescribing guidance: CCG websites***

## **West Suffolk**

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

## **East Suffolk**

<http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/Medicalconditions/Pain.aspx>

## **Knowledge Anglia**

<https://www.knowledgeanglia.nhs.uk/KMS/SouthNorfolk/Home/Prescribing,PharmacyandMedicinesOptimisation/PrescribingAZ/Pain.aspx>

# Acute Pain

**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<sup>1,2,4,5</sup>

**Preferred and alternative options after optimising non-pharmacological strategies**

<b>MILD STEP 1</b>	<p><b>Paracetamol</b> oral/rectal 1g qds (1g tds if &lt; 50 kg, malnourished, renal or hepatic impairment) Paracetamol alone is not recommended management for low back pain<sup>1</sup></p> <p><b>ibuprofen</b> oral 400 mg tds. Topical 5% gel tds OR <b>Naproxen</b> oral 250-500 mg bid NSAID at lowest effective dose for shortest period. Consider a PPI</p> <p><i>Consider possibility of neuropathic pain; refer to neuropathic pain ladder</i></p>	<p><b>Adjuvant therapies</b></p> <ul style="list-style-type: none"> <li>• Muscle relaxants, e.g. baclofen</li> <li>• Benzodiazepines - short term only and extreme caution with strong opioids</li> </ul>																		
<b>MODERATE STEP 2</b> ADD weak opioid	<p><b>Codaine</b> oral 15-60 mg qds Avoid if breast feeding or if patient has experienced excessive response to codaine previously<sup>4</sup></p> <p>OR</p> <p><b>Tramadol</b> oral 50-100 mg qds OR <b>Meptazinol</b> oral 200 mg 3-6 hourly</p>	<p><b>Age related dose for oral solution 4-6 hourly</b></p> <table border="1"> <thead> <tr> <th>Age</th> <th>Morphine</th> <th>Oxycodone</th> </tr> </thead> <tbody> <tr> <td>16-35</td> <td>7.5-12.5 mg</td> <td>3 mg/6 mg</td> </tr> <tr> <td>40-50</td> <td>5-10 mg</td> <td>2.5-5 mg</td> </tr> <tr> <td>60-69</td> <td>2.5-7.5 mg</td> <td>1.25-3 mg</td> </tr> <tr> <td>70-85</td> <td>2.5-5 mg</td> <td>1.25-2.5 mg</td> </tr> <tr> <td>&gt;85</td> <td>2.5 mg</td> <td>1.25 mg</td> </tr> </tbody> </table>	Age	Morphine	Oxycodone	16-35	7.5-12.5 mg	3 mg/6 mg	40-50	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
Age	Morphine	Oxycodone																		
16-35	7.5-12.5 mg	3 mg/6 mg																		
40-50	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																		
<b>SEVERE STEP 3</b> STOP weak opioid	<p><b>Morphine Sulfate</b> oral solution up to 4-6 hourly: <b>age related dose</b> OR <i>if patient intolerant to morphine</i></p> <p><b>Oxycodone</b> oral solution up to 4-6 hourly: <b>age related dose</b></p> <p><i>Strong opioid at lowest effective dose for expected duration of pain. &lt; 2 days usually sufficient, 7 days rarely needed.</i></p>																			

**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**

Aim to stop strong opioids commenced for post-operative pain within 2 weeks of surgery.

Do not prescribe lortalamine for acute pain (risk of serious adverse effects and fatalities reported).

Tertiary generally only for palliative care.

Pain > 3 months: Refer to chronic pain ladder.

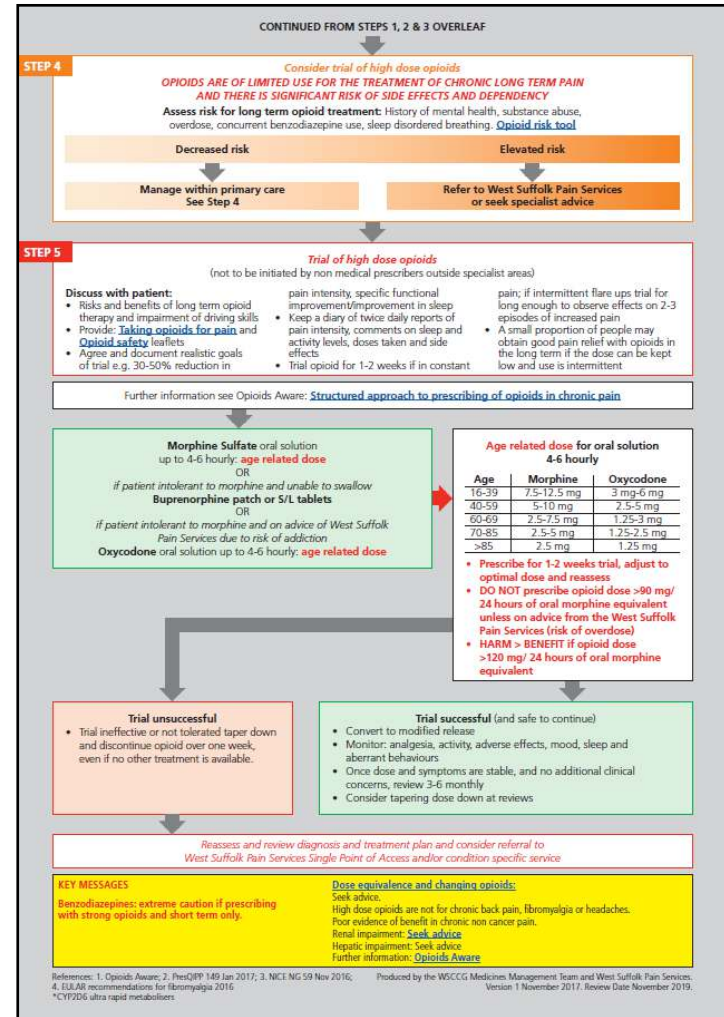
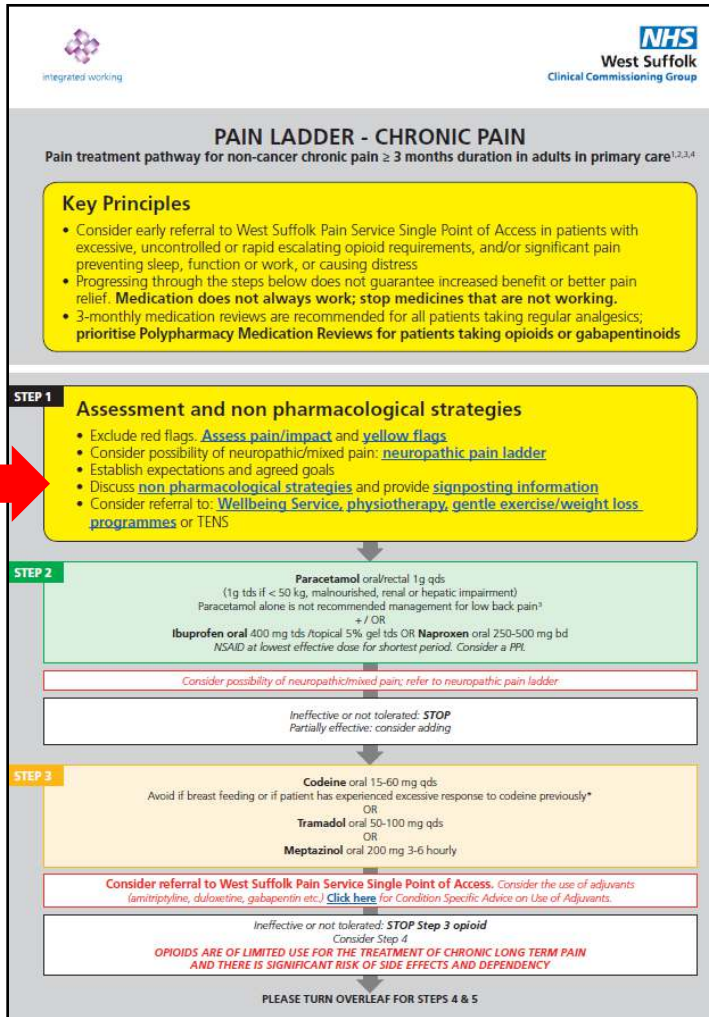
Consider seeking advice or refer to **West Suffolk Pain Services Single Point of Access** if red flag have been excluded AND diagnosis and treatment plan have been reviewed AND:

- ETORICOXIB opioid dose significantly increased
- OR step 1 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 drowsiness or significant pain preventing sleep, function or work.

tel West Suffolk Community Pain Services 0645 241 3313 option 6, WSH Pain Services, 01284 712528.

<sup>1</sup> NPS 2016. <sup>2</sup> NPS 2016. <sup>3</sup> NPS 2016. <sup>4</sup> NPS 2016. <sup>5</sup> NPS 2016. <sup>6</sup> NPS 2016. <sup>7</sup> NPS 2016. <sup>8</sup> NPS 2016. <sup>9</sup> NPS 2016. <sup>10</sup> NPS 2016. <sup>11</sup> NPS 2016. <sup>12</sup> NPS 2016. <sup>13</sup> NPS 2016. <sup>14</sup> NPS 2016. <sup>15</sup> NPS 2016. <sup>16</sup> NPS 2016. <sup>17</sup> NPS 2016. <sup>18</sup> NPS 2016. <sup>19</sup> NPS 2016. <sup>20</sup> NPS 2016. <sup>21</sup> NPS 2016. <sup>22</sup> NPS 2016. <sup>23</sup> NPS 2016. <sup>24</sup> NPS 2016. <sup>25</sup> NPS 2016. <sup>26</sup> NPS 2016. <sup>27</sup> NPS 2016. <sup>28</sup> NPS 2016. <sup>29</sup> NPS 2016. <sup>30</sup> NPS 2016. <sup>31</sup> NPS 2016. <sup>32</sup> NPS 2016. <sup>33</sup> NPS 2016. <sup>34</sup> NPS 2016. <sup>35</sup> NPS 2016. <sup>36</sup> NPS 2016. <sup>37</sup> NPS 2016. <sup>38</sup> NPS 2016. <sup>39</sup> NPS 2016. <sup>40</sup> NPS 2016. <sup>41</sup> NPS 2016. <sup>42</sup> NPS 2016. 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# Chronic Pain



# Use adjuvants appropriately



## Management of back pain and sciatica

- NICE guidance [NG59](#) on Low back pain and sciatica in over 16s: assessment and management, recommends **oral NSAIDs for low back pain** at the lowest effective dose for the shortest possible period of time, taking into account potential gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.
- If a NSAID is contraindicated, not tolerated or has been ineffective, **weak opioids (with or without paracetamol)** may be considered for managing **acute low back pain** only.
- **Paracetamol alone** should **not** be offered.
- **Do not offer opioids for managing chronic low back pain.**
- **Non pharmacological** interventions and **self-management** should be encouraged at all steps of the treatment pathway including:
  - Provision of advice and information tailored to need
  - Encouragement to continue with normal activities
  - Exercise programmes – see:  
<https://www.versusarthritis.org/about-arthritis/conditions/back-pain/#Exercises-to-manage-back-pain>  
<https://www.nhs.uk/live-well/exercise/lower-back-pain-exercises/>

## Management of Osteoarthritis

- NICE guidance [CG177](#) Osteoarthritis: care and management recommends that all people with osteoarthritis should be offered the following core treatments in addition to taking a holistic approach to assess the effect of osteoarthritis on the person's function, quality of life, occupation, mood, relationships and leisure activities:
  - Access to appropriate **information** to enhance understanding of condition and management
  - Interventions to support **weight loss** if over-weight or obese
  - **Exercise** irrespective of age, co-morbidity, pain severity and disability including: Muscle strengthening, aerobic fitness, manipulation and stretching – see  
<https://www.versusarthritis.org/about-arthritis/managing-symptoms/exercise/exercises-to-manage-pain/>
- Pharmacological treatments can be considered in addition to the above core treatments such **regular paracetamol** and /or **topical NSAIDs**.
- Where paracetamol or topical NSAIDs are **ineffective** then **substitution** with an oral **NSAID/COX-2 inhibitor** should be considered.
- Where paracetamol or topical NSAIDs provide **insufficient** pain relief then the **addition** of an **oral NSAID/COX-2 inhibitor** to paracetamol should be considered.
- Consider if there is an element of neuropathic pain: refer to [Key Message Bulletin 7: Neuropathic pain](#) and [NICE CG173](#) Neuropathic pain in adults: pharmacological management in non-specialist settings

<https://www.knowledgeanglia.nhs.uk/KMS/SouthNorfolk/Home/Prescribing,PharmacyandMedicinesOptimisation/PrescribingAZ/Pain.aspx>



West Suffolk  
Clinical Commissioning Group

### Condition Specific Advice on Use of Adjuvants

This advice applies to the use of adjuvants (amitriptyline, duloxetine, gabapentin etc.) for the treatment of chronic pain  
*Refer to the Neuropathic Pain Ladder for doses and titration details*

**Fibromyalgia <sup>1</sup>**  
*Severe Pain*

- Duloxetine
- Pregabalin (on advice from West Suffolk Pain Services)
- Tramadol (with or without paracetamol)
- Do not proceed to trialling stronger opioids for fibromyalgia without advice from the West Suffolk Pain Services

*Severe sleep disturbance*

- Amitriptyline (low dose)
- Pregabalin at night (on advice from West Suffolk Pain Services)

**Chronic Back Pain <sup>2</sup>**

- For recommendations on managing sciatica see [Neuropathic Pain Ladder](#)
- Do not offer selective reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors or tricyclic antidepressants for low back pain
- Do not offer anticonvulsants for low back pain
- Do not proceed to trialling opioids for chronic back pain without advice from the West Suffolk Pain Services

**Osteoarthritis <sup>3</sup>**

- Duloxetine (reduces pain and disability)

**Chronic headaches <sup>3</sup>**

- Tricyclic antidepressants
- Do not proceed to trialling opioids for chronic headaches

**Complex Regional Pain Syndrome <sup>4,5</sup>**

- Refer urgently to WSFT physiotherapy department and discuss with West Suffolk Pain Services Phone 01284 712528 (clinical answer phone).
- If simple medications do not reduce pain in 3-4 weeks refer to the [Neuropathic Pain Ladder](#). Earlier use may be appropriate
- Do not proceed to trialling stronger opioids without advice from the West Suffolk Pain Services

**West Suffolk Pain Services may recommend pharmacological management outside the above guidance**

**Key messages**  
**Further prescribing information**  
**Slow titration:** elderly/frail or adverse effects with higher doses  
Seek advice on dose adjustment before prescribing to patients with renal or hepatic impairment  
Discuss benefits and risks of drug therapy, titration regimen and impairment to driving: [Patient medication leaflet](#)  
Agree realistic goals - 30-50% pain reduction and specific functional improvement/Improvement in sleep  
Review efficacy. **If ineffective stop.** See [Neuropathic Pain Ladder](#) for discontinuation information  
Once dose and symptoms are stable, and no additional clinical concerns, review 3-6 monthly.

This guidance recommends certain drugs for indications for which there is no UK marketing authorisation. The prescriber should follow relevant professional guidance, provide patient information and take full responsibility for the decision. Informed consent should be documented.

**References**

1. EULAR Recommendations for Fibromyalgia 2016
2. NICE NG59. Low back pain and sciatica in over 16s: Nov 2016
3. ANZCA. Acute pain management scientific evidence 4<sup>th</sup> edition, 2015
4. RCP. Complex regional pain syndrome in adults. UK guidelines. 2012
5. Netherlands updated guidelines for CRPS Type 1. 2015

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

<https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2017/11/Condition-Specific-Advice-on-Use-of-Adjuvants-Final-Nov-2017.pdf>



# Provide written patient information



## 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:

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



## Driving and Pain

### Guidance for Faculty of Pain Medicine Members

#### Introduction

Road traffic accidents remain a significant public health problem in the UK. In 2016 there were over 180,000 casualties resulting from driving accidents in Britain.<sup>1</sup> Despite a steady decline in deaths on UK roads (from a peak in 1966), around 1800 people a year still die in road accidents. This figure has remained largely unchanged since 2010. The top two contributing factors that led to crashes that resulted in a death were 'loss of control' and 'failing to look properly'.<sup>2</sup> There is also a strong link between fatal crashes and night time driving, with such crashes much more likely to occur between the hours of 11pm and 6am.

Indeed, fatigue and tiredness may be a contributory factor in as many as 20% of all road accidents.<sup>3</sup>

Driving remains a complex dynamic task and chronic pain may affect a number of factors that influence driver performance. Pain conditions themselves may effect ability to drive, as may medications and co-morbid conditions. Driving safely depend on three integrated processes: perception, decision and reaction, and as such relies on eyes, brain and musculoskeletal systems working together.

This guidance summarises current understanding of the way in which Chronic pain may affect driving, the effects of current legislation on pain doctors and patients, and how to advise patients on this topic.

#### The effect of pain on driving

Pain itself has the potential to affect driving performance through adverse effects on physical function and cognition. For example, musculoskeletal conditions can cause difficulty with the physical act of driving e.g. people with low back pain may experience difficulties using foot pedals.<sup>4</sup> Tests of 'on road' driving performance show that patients with chronic non-malignant pain perform poorly compared to matched healthy controls.<sup>5</sup> When surveyed, 70% of chronic pain patients indicated that pain limited their driving in some way, with 41% experiencing either quite a bit of difficulty or a great deal of difficulty driving.<sup>6</sup> The self reported prevalence of difficulty performing basic safety manoeuvres such as checking for traffic by looking over the shoulder was 57%.



# Recognise who is likely to be harmed?

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 benzodiazepines/sedative/hypnotic drugs



# Know the indicators for tapering

**Integrated working** **NHS West Suffolk Clinical Commissioning Group**

## OPIOID TAPERING FOR CHRONIC NON-CANCER PAIN

Guidance for adults in primary care<sup>1,2</sup>

**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 benzodiazepines, gabapentinoids or sedatives

Further information: Indicators for dependence

Lower risk → Higher risk

Manage within Primary Care

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 appointments
- 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<sup>1,2</sup>

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 gain
- 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 benzodiazepines
- 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, tramidine: on advice by West Suffolk Pain Services: 01284 712528

- 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 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 712528

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.nca.ac.uk/faculty-of-pain-medicine/opioids-aware>

2. [http://nationalpaincentre.northern-california.org/step\\_4.pdf](http://nationalpaincentre.northern-california.org/step_4.pdf)

# Recognise drug seeking behaviour

(PresQUIPP 2019)

218. Reducing opioid prescribing in chronic pain 2.2

## Appendix 2: Indicators that suggest the possibility of dependence that should be explored with those on a long term opioid prescription

<http://www.roac.ac.uk/faculty-of-pain-medicine/opioids-aware/clinical-use-of-opioids/identification-and-treatment>

- Long term prescribing of opioids for non-cancer conditions.
- Current or past psychiatric illness or profound emotional trauma.
- Reports of concern by family members or carers about opioid use.
- Concerns expressed by a pharmacist or other healthcare professionals about long term opioid use.
- Insistence that only opioid treatment will alleviate pain and refusal to explore other avenues of treatment.
- Refusal to attend or failure to attend appointments to review opioid prescription.
- Resisting referral for specialist addiction assessment.
- The repeated seeking of prescriptions for opioids with no review by a clinician.
- Repeatedly losing medications or prescriptions.
- Taking doses larger than those prescribed or increasing dosage without consulting the clinician; often coupled with seeking early replacement prescriptions. Associated with continued requests for dose escalations.
- Seeking opioids from different doctors and other prescribers. This can take place within GP practices, often identifying locum doctors or doctors unfamiliar with their case. This may be associated with attempting unscheduled visits.
- Obtaining medication from multiple different providers, NHS and private GPs, repeatedly and rapidly deregistering and registering with GPs, seeking treatment for the same condition from both specialists and GP; or seeking treatment from multiple specialists. This may be coupled with a refusal to agree to writing to the main primary care provider.
- Obtaining medications from the internet or from family members or friends.
- Resisting referrals to acute specialists about complex physical conditions or failing to attend specialist appointments.
- Appearing sedated in clinic appointments.
- Misusing alcohol or using illicit or over the counter, internet or other prescribed drugs or a past history of alcohol or other drug dependence.
- Deteriorating social functioning including at work and at home.
- Resisting or refusing drug screening.
- Signs or symptoms of injecting opioids or snorting oral formulations.

## Opioids aware: Recognising and managing drug seeking behaviour

Ruth Bastable GP

## Saying 'no': declining requests for DFMs


Ruth Bastable GP

# Know what do if a patient is unfit to drive?

Driver & Vehicle Licensing Agency

## Assessing fitness to drive

– a guide for medical professionals



www.gov.uk/dvla/fitness todrive

March 2019

You can find the latest version of this guidance on our website at [www.gmc-uk.org/guidance](http://www.gmc-uk.org/guidance)

General Medical Council

## Confidentiality: patients' fitness to drive and reporting concerns to the DVLA

1 In our guidance Confidentiality: good practice in handling patient information we say:

1. Trust is an essential part of the doctor-patient relationship and confidentiality is central to this. Patients may avoid seeking medical help, or may under-report symptoms, if they think that their personal information will be disclosed by doctors without consent, or without the chance to have some control over the timing or amount of information shared.
60. Doctors owe a duty of confidentiality to their patients, but they also have a wider duty to protect and promote the health of patients and the public.
62. You should ask for a patient's consent to disclose information for the protection of others unless the information is required by law or it is not safe, appropriate or practicable to do so. You should consider any reasons given for refusal.
64. If it is not practicable or appropriate to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential.

Working with doctors Working for patients

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 are 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: 01793 782337 (10.30-13.00 hrs Monday to Friday)

**STEP 1**

If a patient's condition or treatment could affect their safety as a driver<sup>1,2,3</sup>

- 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 it 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<sup>1,2,3</sup>

- Make every reasonable effort to persuade
- Discuss with the patient that health care professionals will report to the DVLA if they persist
- If warnings are ignored, consider the risk
- If you think refusal to stop driving leaves a patient in danger, and the patient does not understand your advice contact confidence to a medical adviser. Where necessary, discuss and consider any objections and advise patient in writing and document

**While respecting patient confidentiality**

**Further information**

- DVLA (2019) [Assessing fitness to drive: a guide for medical professionals](#)
- Faculty of Pain Medicine [Driving and Pain, Information for Patients](#)
- Faculty of Pain Medicine [Driving and Pain, Guidance for Medical Professionals](#)
- DVLA contact: [medadvice@dvla.gov.uk](mailto:medadvice@dvla.gov.uk)
- Telephone: 01793 782337 (10.30-13.00 hrs Monday to Friday)

**References**

1. DVLA (2019) [Assessing fitness to drive: a guide for medical professionals](#)
2. GMC Confidentiality: good practice in handling patient information
3. Fernan A, O'Neill D, McNeill C (2019) [What should I do when a patient is unfit to drive?](#)

CAREERS CLINIC


## What should I do when my patient is not fit to drive?



It can be difficult if a motorist ignores your medical advice to stop driving, but guidance is available, experts tell **Abi Rimmer**

*Widdett*

# Know how to support self-management



## Persistent pain

**Its impact:**

- Sleep problems
- Loss of fitness
- Money worries
- Medication side effects
- Feeling low
- Stress + fear, anger, shame
- Grief and loss
- Relationship worries

**Circle three areas that need to change now**  
To find out more about how to change these areas, explore options with your clinician

**my LiveWell withpain**  
© My Live Well with Pain 2018

# 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.
4. **It should be emphasised the medicines only play a minor part in managing chronic pain**



**PAIN LADDER - CHRONIC PAIN**  
Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care<sup>1,2,3,4</sup>

**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



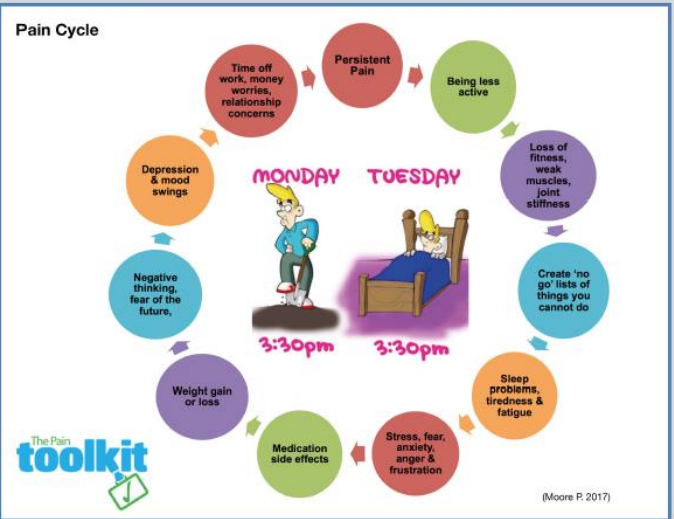
# Non-pharmacological hyperlinks

 **West Suffolk**  
Clinical Commissioning Group

integrated working

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

**Pain Cycle**



**The Pain toolkit**

(Moore P. 2017)

**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.

 **West Suffolk**  
Clinical Commissioning Group

integrated working

**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 toolkit.

[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.

# New websites developed by clinicians for clinicians and patients

## For clinicians

The screenshot shows the homepage for clinicians. At the top is the 'Live Well with Pain' logo and a navigation menu with 'About', 'Resources', 'News', and 'Contact'. A 'DONATE' button is also visible. Below the navigation is a featured article titled 'Shifting the conversation' with a sub-headline 'How to move patients towards taking control of their pain' and a 'Find out more' button. A welcome message follows: 'Welcome to Live Well with Pain, developed by clinicians, for clinicians to help you support your patients towards better self management of their long term pain.' Below this is a blue banner with the 'my Live Well with Pain' logo and the text 'Living with pain? Visit My Live Well with Pain for really useful information and resources to help you live well, despite the pain'. A 'Resources for clinicians' button is positioned above three resource cards: 'Resources for your patients', 'Empowering patients to self manage', and 'Opioid Zone'. At the bottom, a small disclaimer states: 'Live Well with Pain is completely free to use, and is full of techniques and resources that GPs and pain specialists have found useful over many years. They will increase your skills and confidence in working with people who live with persistent pain.'

[livewellwithpain.co.uk/](http://livewellwithpain.co.uk/)

## For patients

The screenshot shows the homepage for patients. At the top is the 'my Live Well with Pain' logo and the text 'For people who are living with pain. Really useful information and resources to help you live well, despite the pain.' Below this is a navigation menu with 'About', 'Resources', 'Links', and 'Contact'. A main message reads: 'My Live Well with Pain is completely free to use, and is full of trusted techniques that people with persistent pain have found useful, in helping them to get on with their lives and live well with pain.' Below this are three buttons: 'Booklets and leaflets', 'Video and audio', and 'Other useful resources'. A featured article titled 'Opioids – should I reduce them?' is displayed with a sub-headline 'Use our handy Decision Guide with your GP to find out what's right for you' and a 'Find out more' button. A large pill graphic with 'no? yes?' is positioned to the right of the article. At the bottom, a blue banner asks 'Are you a GP or pain specialist?' and provides the text: 'Visit Live Well with Pain for professional tools and resources to help you increase your skills and confidence in working with people with persistent pain.'

[my.livewellwithpain.co.uk/](http://my.livewellwithpain.co.uk/)



# My Live Well with Pain



## Explaining Pain

Understand more about pain and how it affects your life



## 10 Opioid Safety Messages

Taking prescribed opioids? Here are ten things you need to know to keep yourself safe...



## Sleep Well with Pain leaflet

This leaflet draws on recent research and offers ideas that people with pain have found helpful



## Ten Footsteps to Living Well with




## Your Journey with Pain



## Sleep problems leaflet

# CPD:PrescQuipp

<https://www.prescquipp.info/learning/prescquipp-e-learning/>




## Reducing opioid prescribing in chronic pain e-learning

The Reducing opioid prescribing in chronic pain e-learning course is CPD certified and is aimed at medicines management teams, GPs, practice nurses, practice pharmacists and non-medical prescribers.

There has been a marked and progressive rise in prescribing of opioid drugs in the UK over the past decade and the trend to increased prescribing continues. The increase in prescribing has been predominantly for the treatment of non-cancer pain.

Opioids have demonstrable effectiveness in the treatment of acute pain and pain related to cancer but there is little evidence for the effectiveness of opioids for the treatment of chronic pain. This e-learning course will help equip healthcare professionals to tackle this growth in use and to improve care for patients with chronic pain and is comprised of eight modules:



- MODULE 1**
  - Background to chronic pain**
    - Definition and the suffering and disability caused by chronic pain
    - The expectations of chronic pain management
    - The approach to chronic pain management with NICE guidelines
- MODULE 2**
  - Opioid efficacy and trial of treatment**
    - The lack of evidence of efficacy of opioids in chronic pain and expectations
    - How an opioid trial should be undertaken, the appropriate duration and how to assess and document the outcomes of the trial
- MODULE 3**
  - Choice of strong opioid**
    - The evidence comparing non-morphine opioids with morphine
    - The rationale for different formulations and routes of administration
    - The approximate dose equivalence of opioids
- MODULE 4**
  - Adverse effects of opioids**
    - The short-term and long-term adverse effects of opioids
    - Withdrawal and addiction symptoms
- MODULE 5**
  - Duration of opioid therapy and review**
    - The rise in prescribing of opioid medicines in the UK
    - The repeat prescribing of opioids is discouraged
    - The need for medication review

- MODULE 6**
  - Tapering and stopping opioids**
    - Improved outcomes anticipated after opioid dose reductions
    - How to taper and stop opioids in practice
- MODULE 7**
  - Prescription opioid dependence**
    - Indicators that suggest the possibility of dependence on prescription opioids
    - The potential need for specialist support for dependent patients
    - The pharmacotherapy that may be prescribed by specialist service for opioid dependent patients during withdrawal
- MODULE 8**
  - Specialist services**
    - Specialist pain services and the variation in access to these across the UK
    - Potential role of specialist drug and alcohol dependence treatment services for patients with opioid dependency

The course includes contributions from Dr Ruth Bastable, a GP with experience of working in health care of patients who are homeless and at risk of homelessness and health care of patients in secure environments. She has an interest in substance misuse, and an interest in prescription drug misuse.

This course should take approximately 3 hours. You'll need to complete all the modules and get at least 70% in the final assessment to pass the course, but you can attempt it up to three times. You'll also need to get 60% in each of the quizzes before you can move on to the next lesson, but you can retake these as many times as necessary.

### Course access

This course is available for all members of our medicines management team and GP practices in our commissioning area.

You will need to be logged in to the PrescQIPP site to access the course, so that it can record your progress and issue your e-learning certificate. If you do not already have a log in for the PrescQIPP site, you can [register here](#). Please ensure that you specify the commissioning area on registration as this will ensure that you are provided with the correct access and do not have to pay for the course.


- Log in to the [PrescQIPP site](#)
- Click on the 'PrescQIPP e-learning' link under the 'Learning' menu, then once on the [E-learning Hub](#) click on 'Access e-learning' on the right hand side
- Find the course and select 'Access course'

Don't forget that you can complete the course over a period of time. To return to the course and pick up where you left off at any time, simply log back into the site and follow the steps above.

Please note that you will need an up to date browser and sufficient bandwidth to view the course. If you have any questions about the course, please contact [hclo@prescquipp.info](mailto:hclo@prescquipp.info).

# CPD:PrescQuipp


<https://www.prescqipp.info/learning/prescqipp-e-learning/>



## Polypharmacy and deprescribing e-learning now available

**Polypharmacy and deprescribing**

The concept of deprescribing is still new to many clinicians and this course explains the principles as well as practical advice as to how it can be undertaken. It has been designed for clinical staff who are involved in the prescribing and review of medicines, including pharmacists and pharmacy technicians; nurses; non-medical prescribers and trainee GPs. A concise version of the course is also available for more experienced healthcare professionals including GPs. The course is split into nine bite sized modules to enable you to take the course at your own pace and speed and takes approximately three and a half hours in total. A CPD certified certificate is available upon completion of the course which requires a pass mark of 80% in the final assessment.



<b>MODULE 1</b>	<b>Introduction</b> <ul style="list-style-type: none"><li>About the course, learning objectives, navigation and pre-course quiz.</li></ul>
<b>MODULE 2</b>	<b>Definitions and principles</b> <ul style="list-style-type: none"><li>Explains the definitions and principles of polypharmacy, prescribing cascades and deprescribing.</li><li>Discussion of deprescribing with patients.</li><li>The concepts of "Numbers needed to treat" and "Numbers needed to harm" and how these relate to individual patients are introduced.</li></ul>
<b>MODULE 3</b>	<b>Multimorbidity</b> <ul style="list-style-type: none"><li>Key recommendations from the NICE Guidance on Multi-morbidity (NG56) guidance – who may benefit and how.</li><li>Introduces the Database of Treatment Effects.</li><li>How multi-morbidity can contribute to inappropriate polypharmacy and how this might be addressed.</li></ul>
<b>MODULE 4</b>	<b>Frailty and end of life care</b> <ul style="list-style-type: none"><li>Definition, identification and consequences of frailty.</li><li>Methods to assess frailty.</li><li>High risk medicines in patients with frailty.</li><li>How to reduce the medicine (pill) burden in patients with frailty and those approaching end-of-life.</li></ul>

<b>MODULE 5</b>	<b>Medicines optimisation and patient centred care</b> <ul style="list-style-type: none"><li>Covers key messages from the NICE Guidance on Medicines Optimisation (CG5).</li><li>How to take a patient-centred approach to the initiation of new medicines and the review of existing medicines.</li></ul>
<b>MODULE 6</b>	<b>Shared decision making</b> <ul style="list-style-type: none"><li>How to undertake shared decision-making relating to initiation of medicines, based on what is important to each person in terms of treatments, health priorities, lifestyle and goals.</li><li>Introduction to Patient Decision Aids and how to use them.</li></ul>
<b>MODULE 7</b>	<b>Tools to support medication review</b> <ul style="list-style-type: none"><li>Importance of medication review.</li><li>What is a "gold standard" medication review?</li><li>Signposts to (and explains) practical resources for undertaking medication review and deprescribing.</li><li>These include tools such as IMPACT, STOPP/START, NO TEARS, 7 Steps, Beers Criteria.</li></ul>
<b>MODULE 8</b>	<b>Case studies</b> <ul style="list-style-type: none"><li>Elizabeth: Negative prescribing cascades.</li><li>Kathleen: Multimorbidity.</li><li>Irene: Reducing pill burden as frailty increases.</li><li>Harry: Shared decision making.</li></ul>
<b>MODULE 9</b>	<b>Final assessment and feedback</b> <ul style="list-style-type: none"><li>Final assessment: Can be taken up to three times and requires a pass mark of 80%.</li><li>Feedback on the course.</li></ul>

### Course access

The course costs £12.50 and can be purchased via PayPal.

You will need to be logged in to the PrescQIPP site to access the course, so that it can record your progress and issue your e-learning certificate. If you do not already have a log in for the PrescQIPP site, you can [register here](#). Please ensure you specify the commissioning area on registration as this may mean you do not have to pay for the course, if your area are subscribed.

- Log in to the [PrescQIPP site](#)
- Click on the 'PrescQIPP e-learning' link under the 'Learning' menu, then once on the [E-learning Hub](#) click on 'Access e-learning' on the right hand side
- Find the course and select 'Access course'

Don't forget that you can complete the course over a period of time. To return to the course and pick up where you left off at any time, simply log back into the site and follow the steps above.

Please note that you will need an up to date browser and sufficient bandwidth to view the course. If you have any questions about the course, please contact [help@prescqipp.info](mailto:help@prescqipp.info).

# CPD:e-PAIN

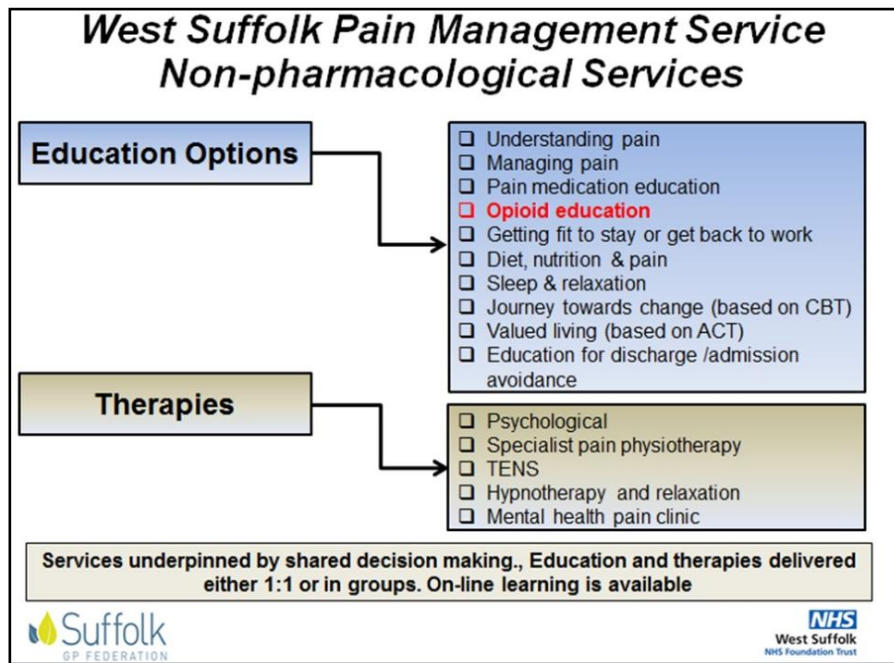
<https://www.rcoa.ac.uk/faculty-of-pain-medicine/e-pain>

The screenshot shows the homepage of the Faculty of Pain Medicine's e-PAIN program. At the top left is the Faculty of Pain Medicine logo. To the right, there is a search bar for 'www.rcoa.ac.uk' and a 'Listen with browsecloud' button. Below the search bar is a 'Back to the RCoA site' link. The main navigation menu on the left includes: Faculty of Pain Medicine Homepage, FPM10, About the FPM, Membership, A Career in Pain Medicine, Events, Core Standards and Commissioning, Guidelines, Consultations and Evidence Base, and Training and Assessment. The main content area features the 'e-PAIN' title with a Twitter icon, a large blue graphic with the text 'e-PAIN e-Learning for Pain Management', and a small video thumbnail titled 'An introduction to the updated ePain programme' featuring Dr. Rhian Lewis.

The following modules are available on e-PAIN:

- > [Module 01: Introducing Pain Management](#)
- > [Module 02: Acute Pain](#)
- > [Module 03: Pain as a Long Term Condition](#)
- > [Module 04: Treatments and Therapies](#)
- > [Module 05: Pain Conditions Around the Body](#)
- > [Module 06: Musculoskeletal](#)
- > [Module 07: Neuropathic Pain](#)
- > [Module 08: Pain in Children](#)
- > [Module 09: Pain in Older People](#)
- > [Module 10: Special Populations](#)
- > [Module 11: Cancer Pain](#)
- > [Module 12: Basic Science](#)

# CPD: WSIPMS



## West Suffolk Pain Services: opioid education

### Evidence/information

- Why have we used strong opioids for persistent pain?
- What lessons have we learnt from using opioids for persistent pain?
- Understanding risks and benefits of long term opioid therapy
- Exploring your risk factors for taking opioids
- What are the current recommendations for the use of opioids in persistent pain?
- Driving and opioids: what should I know?
- Improving the safety of taking opioids in pain: what can you do?

### Opioid tapering

- Overuse of opioids: exploring common reasons
- What are the challenges and benefits of reducing opioids?
- Useful tips for reducing opioids
- Dose reduction or not: what are your options?
- Useful resources



# CPD

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# Summary: a good prescription

(Stannad 2016, 2018 )



## 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 (for surgery, hospital clinic, community pharmacy) 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 'Recommendations').

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 opioids in the United Kingdom. There is also professional and governmental concern regarding misuse of opioids and the number of prescriptions of opioid analgesics. The backdrop are the serious concerns in the USA. This document sets out the issues and recommendations for action in the UK.

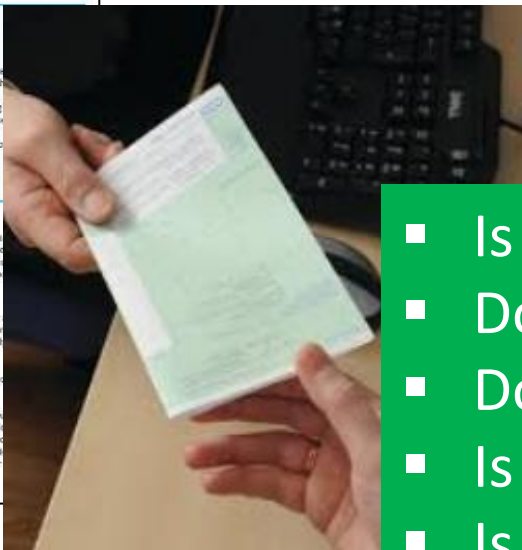
### Opioids in Chronic non-malignant pain

Pain is the 2th vital sign and pain relief can be viewed as a basic human right. Opioids play a role in acute pain where there is a close relationship between pain and tissue damage. Examples would be in Emergency Departments after trauma or following surgery. They are frequently used as a "gold standard" for such acute pain treatment.

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

The effectiveness of opioids in long-term chronic non-malignant pain is less clear. Ten to fifteen years ago, emerging literature led to a view that opioids may play a role in long-term pain. New opioid preparations were brought to the market with this in mind. While the evidence did not support this, it was recognised that it would be very difficult to undertake such long-term trials. There was a strong clinical view that opioids were helpful in some patients not treatable by other means, 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

# *Key resources*

- Dorset Opioid Prescribing Pack for Chronic Pain  
<http://www.uea.ac.uk/documents/899297/29608794/Dorset+Opioid+resource+pack+FINAL.V1.pdf/3374744b-9efa-8f5f-7cad-5b86e7b1289e>
- NHSE are promoting practices (and pharmacies) to undertake high dose opioid audits (doses >120mg morphine or equivalent). The audit can be accessed via the following link: <https://www.prescqipp.info/component/downloads/category/420-high-dose-opiate-searches>
- NICE (NG 46 September 2016) Controlled Drugs: Safe use and management  
<https://www.nice.org.uk/guidance/ng46>
- NICE (KTT 21 January 2017) Medicines Optimisation in long term pain  
<https://www.nice.org.uk/advice/ktt21>
- Opioids Aware 2015: <https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware>
- PresQIPP 218 Feb 2019. Reducing opioids prescribing in chronic pain
- PresQIPP 149 Jan 2017. Management of non neuropathic pain
- Stannard C. 2018 Where now for opioids in chronic pain. <https://dtb.bmj.com/content/56/10/118>
- Stannard C. 2018 Pain and pain prescribing: what is in a number? *British Journal of Anaesthesia*, 120 (6):1147-1149
- WSCCG Pain Guidance <https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/>
- Quality Prescribing for Chronic Pain. A Guide for Improvement 2018-2021  
<http://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/03/Strategy-Chronic-Pain-Quality-Prescribing-for-Chronic-Pain-2018.pdf>



# *Summary*

- Opioids are valuable in the management of acute pain, pain related to cancer and for pain management at the end of life.
- There is a lack of robust evidence on the benefit of long-term opioids in the management of chronic pain.
- Ensure you are able to explain chronic pain and support self-management strategies.
- Inappropriate use of long-term opioids in chronic pain is associated with serious adverse effects.
- The risk of harm from opioids increases significantly above a dose equivalent to 120 mg/day of oral morphine.
- Identify patients most at risk of harm e.g. high dose & adverse selection.
- In conjunction with the patient, regularly review the effect of opioid therapy and consider whether there is a need to reduce the dose or stop the opioid.
- Be aware of and follow local or national guidance

# Questions?

# Thank you

Further information and additional references

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