Reducing the risks with prescription opioids

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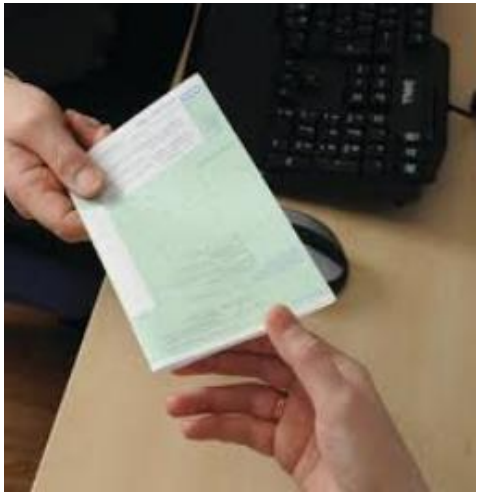
July 2019

Suffolk GP FEDERATION

West Suffolk NHS
NHS Foundation Trust

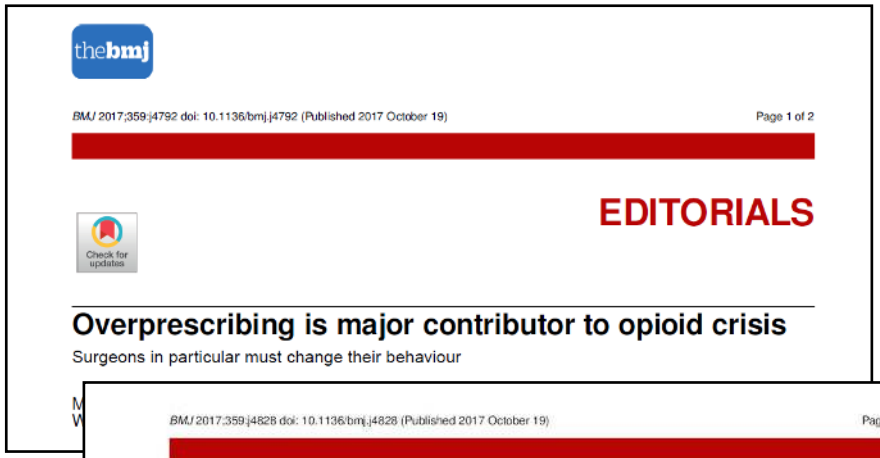
Outline



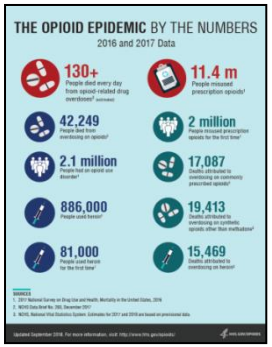
Prescription opioids

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

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)

'Unnecessary' painkillers could leave thousands addicted, doctors warn

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

NHS accused of fuelling rise in opioid addiction

By David Rhodes
BBC News

15 March 2018

Concerns raised as opioid prescriptions rise across UK

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.

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.

BRITAIN'S OPIOID CRISIS

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 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.

GPs 'dished out opioid tablets over internet'

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

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

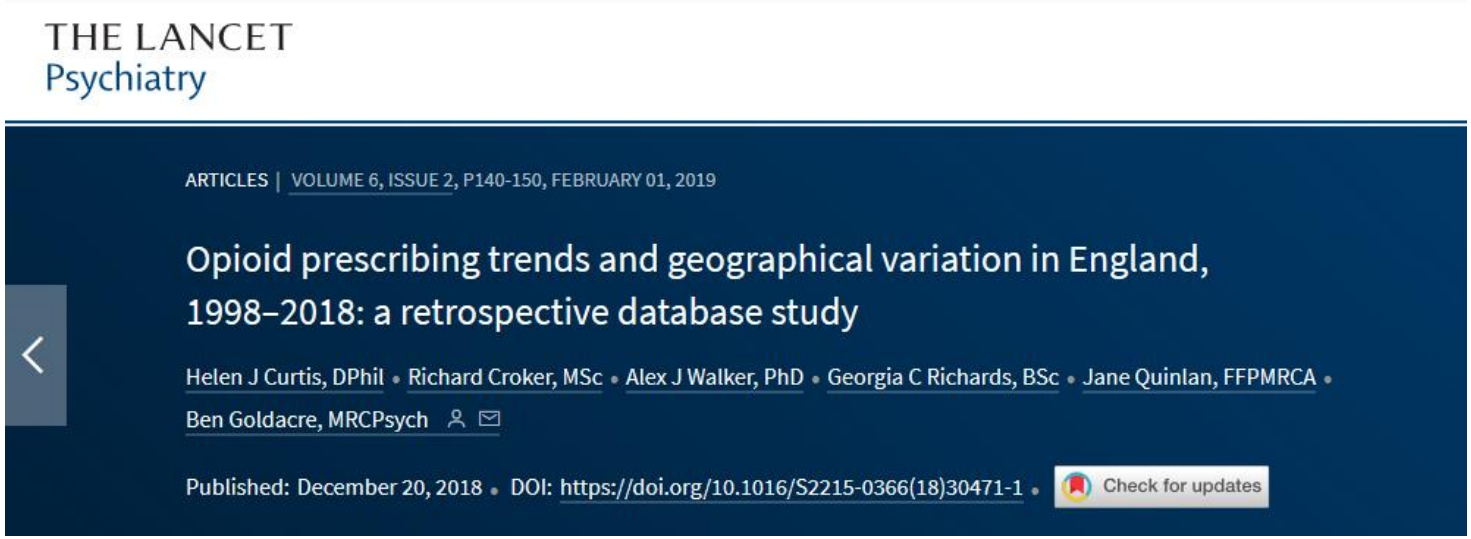
4. Risks

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

What the public is being told

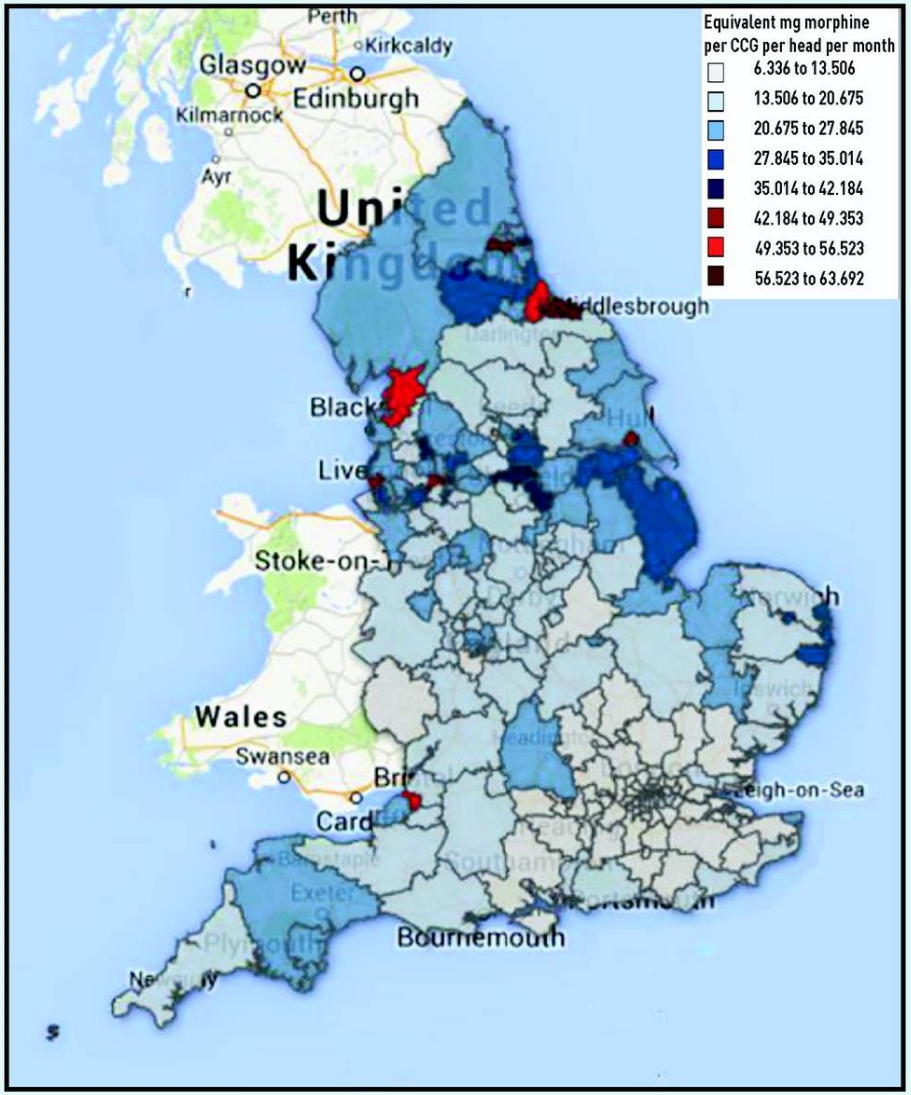
Sunday Times 2019

- 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 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



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

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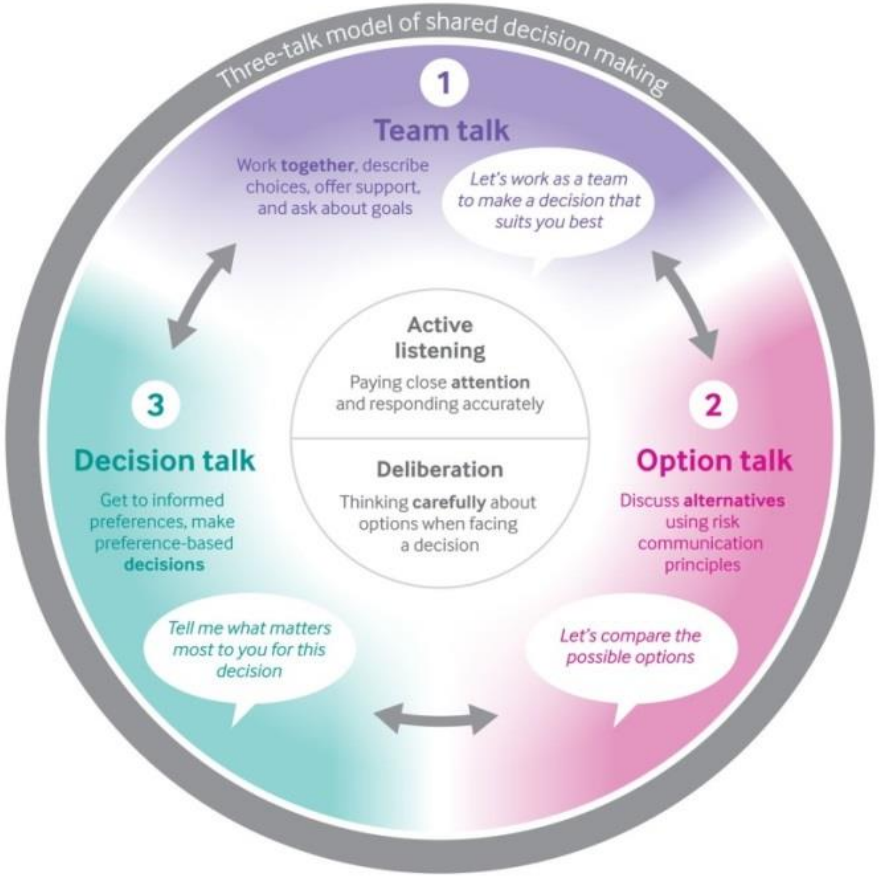
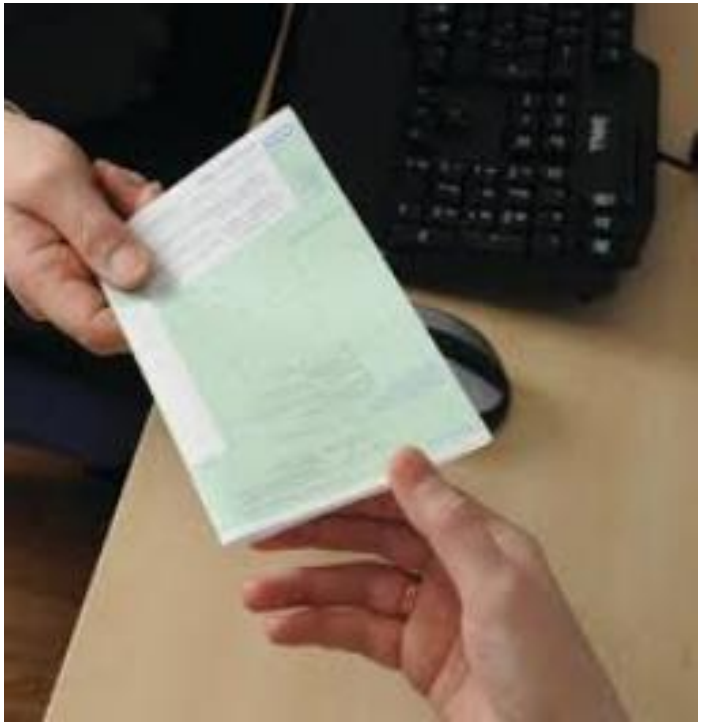
BJGP British Journal of General Practice
bringing research to clinical practice

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	**Respiratory depression** 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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News story

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.

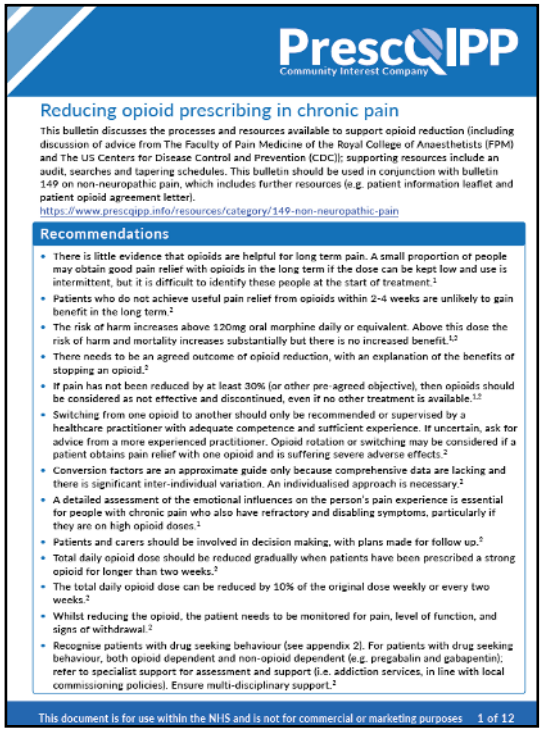
Published 13 February 2019
From: Medicines and Healthcare products Regulatory Agency

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

Michael Steward michael.steward@archant.co.uk @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 precsribing



Opioids Aware

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

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.

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 difficult to identify these people at the point of initiation).

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120 mg/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 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

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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.

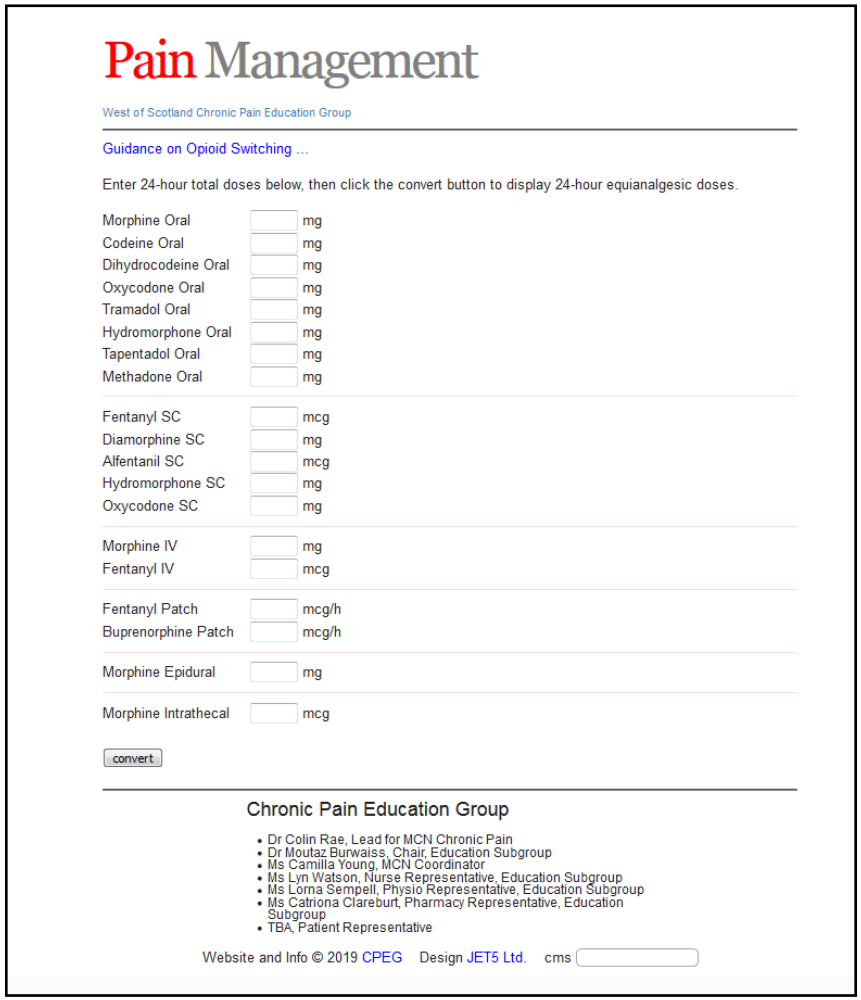
RECOMMENDATIONS

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

Chronic Pain Education Group

- Dr Colin Rae, Lead for MCN Chronic Pain
- Dr Moutaz Burwaiss, 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/

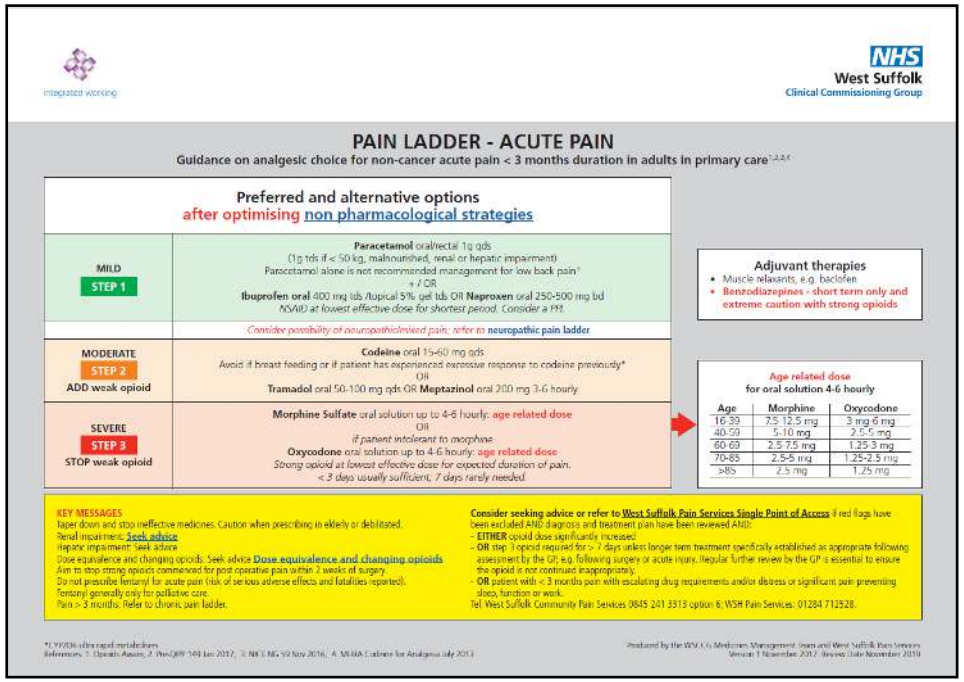
East Suffolk

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



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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[5]
+ / 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

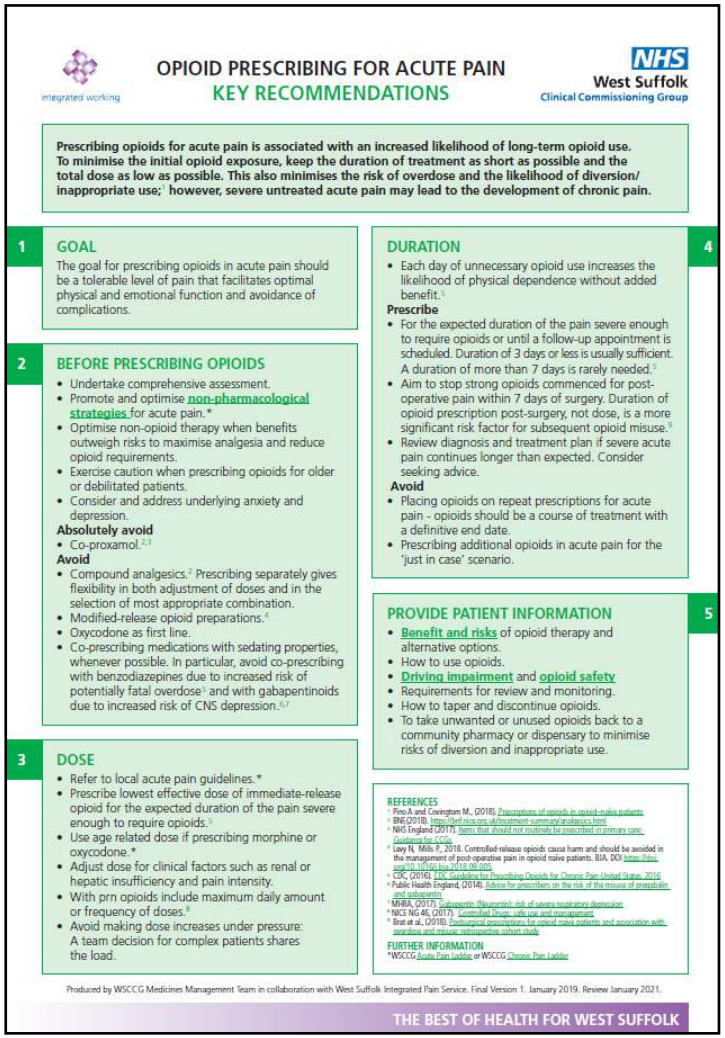
KEY MESSAGES
Taper down and stop ineffective medicines. Caution when prescribing in elderly or debilitated.
Renal impairment: Seek advice
Hepatic impairment: Seek advice
Dose equivalence and changing opioids: Seek advice **Dose equivalence and changing opioids**
Aim to stop strong opioids commenced for 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 3318 option 8; WSH Pain Services: 01284 712528.

*CYP/36 ultra rapid metabolisers
References: 1. Opioids Aware, J. Pin(209-14) Jan 2012, 2. NICE NG 59 Nov 2016, 4. MHRA Guidance for Analgesics 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

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). https://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, Pregabalin: 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.

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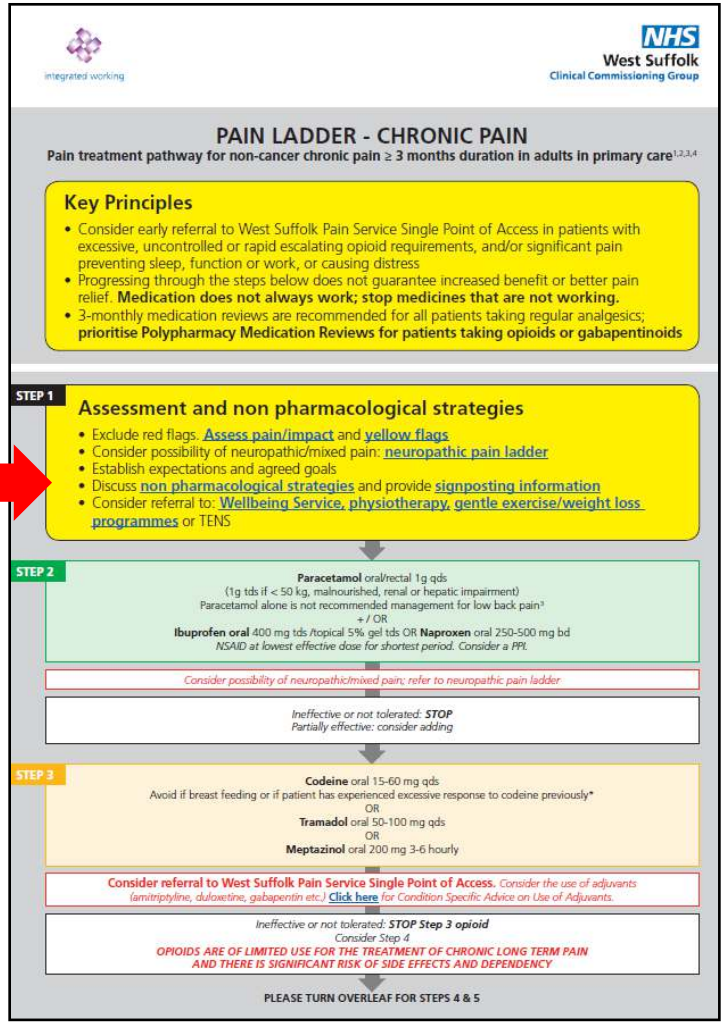
Chronic Pain



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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

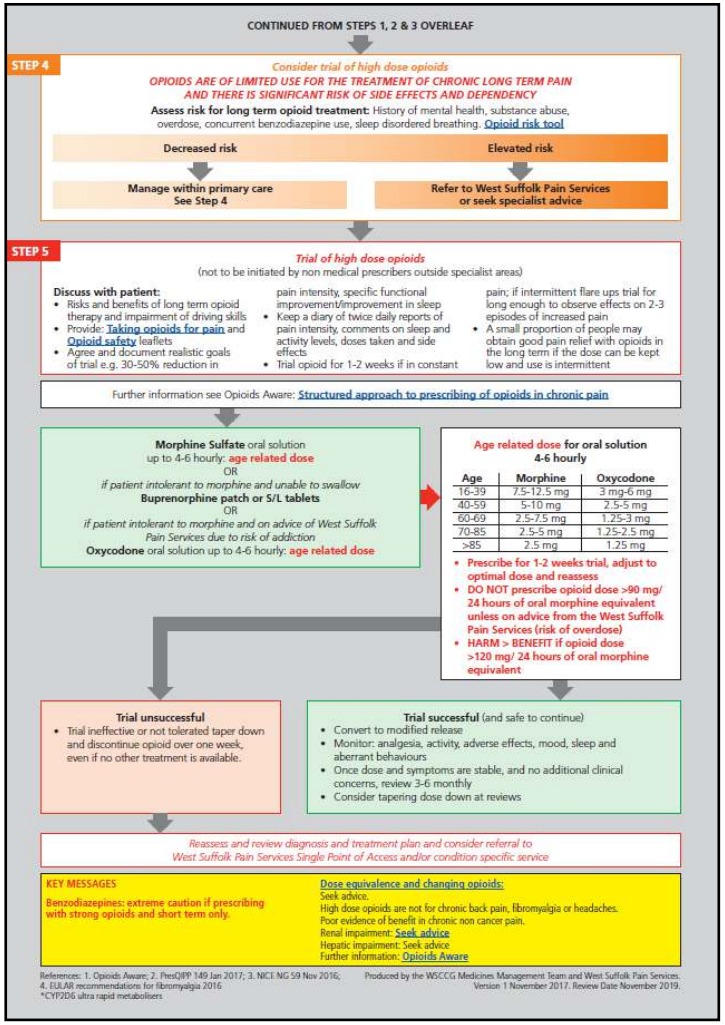
STEP 3

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. PresQIPP 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.

Use adjuvants appropriately

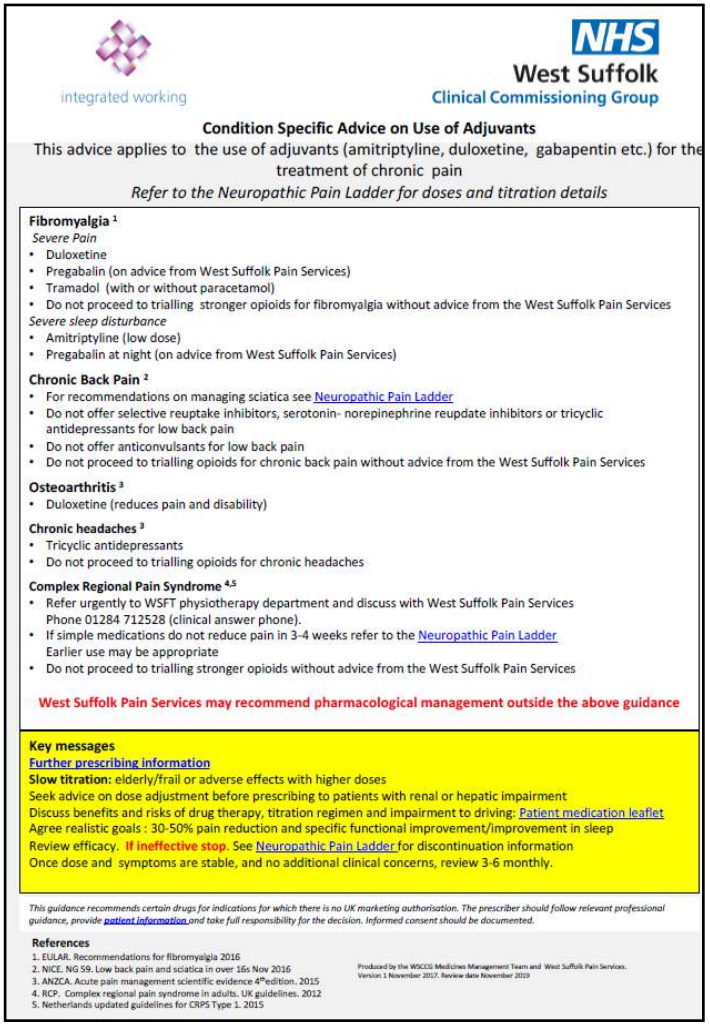
Management of back pain and sciatica

- **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



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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 [1]

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 [2]
- For recommendations on managing sciatica see Neuropathic Pain Ladder
- Do not offer selective reuptake inhibitors, serotonin- norepinephrine reupdate 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 [3]
- Duloxetine (reduces pain and disability)

Chronic headaches [3]
- Tricyclic antidepressants
- Do not proceed to trialling opioids for chronic headaches

Complex Regional Pain Syndrome [4,5]
- 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.

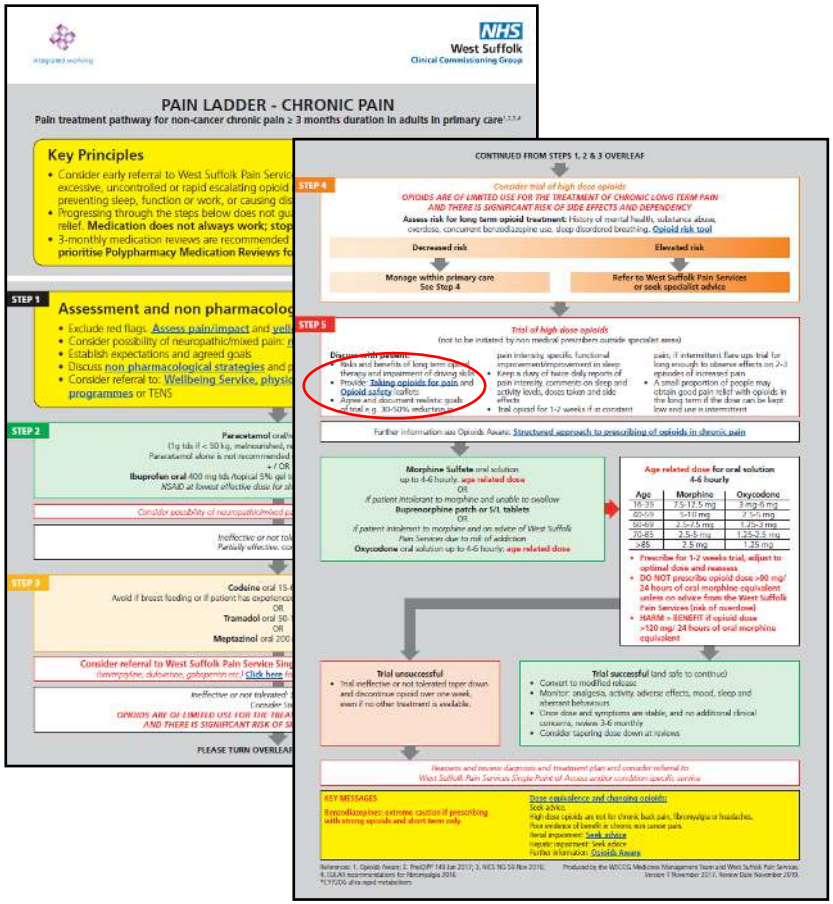
References

1. EULAR. Recommendations for fibromyalgia 2016
2. NICE. NG 59. Low back pain and sciatica in over 16s Nov 2016
3. ANZCA. Acute pain management scientific evidence 4thedition. 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

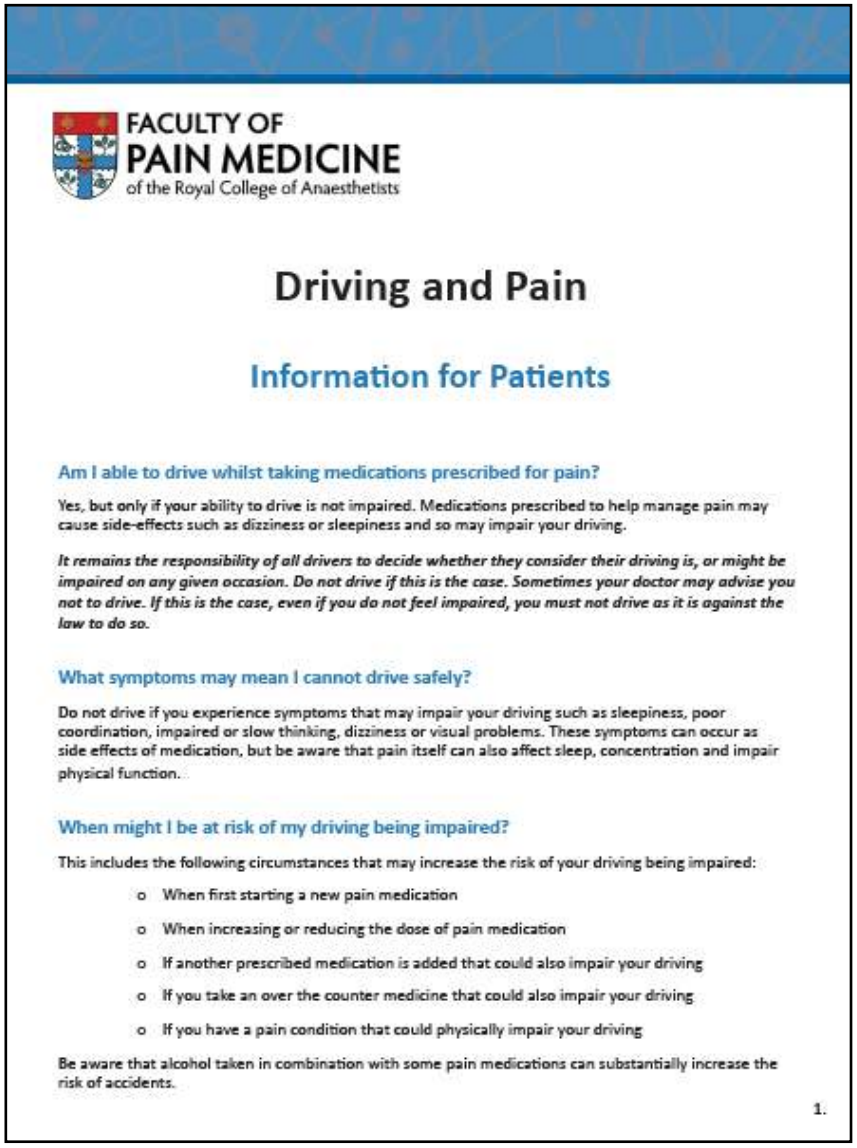
https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2017/11/Condition-Specific-Advice-on-Use-of-Adjuvants-Final-Nov-2017.pdf

Provide written patient information



- https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/
- www.rcoa.ac.uk/system/files/FPM-OA-taking-opioids-for-pain.pdf
- suffolkfed.org.uk/wp-content/uploads/2017/04/Leaflet_Opioids-and-ten-safety-messages-Approved-19-05-16-003.pdf

Provide written patient information



FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Driving and Pain

Information for Patients

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

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

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

What symptoms may mean I cannot drive safely?

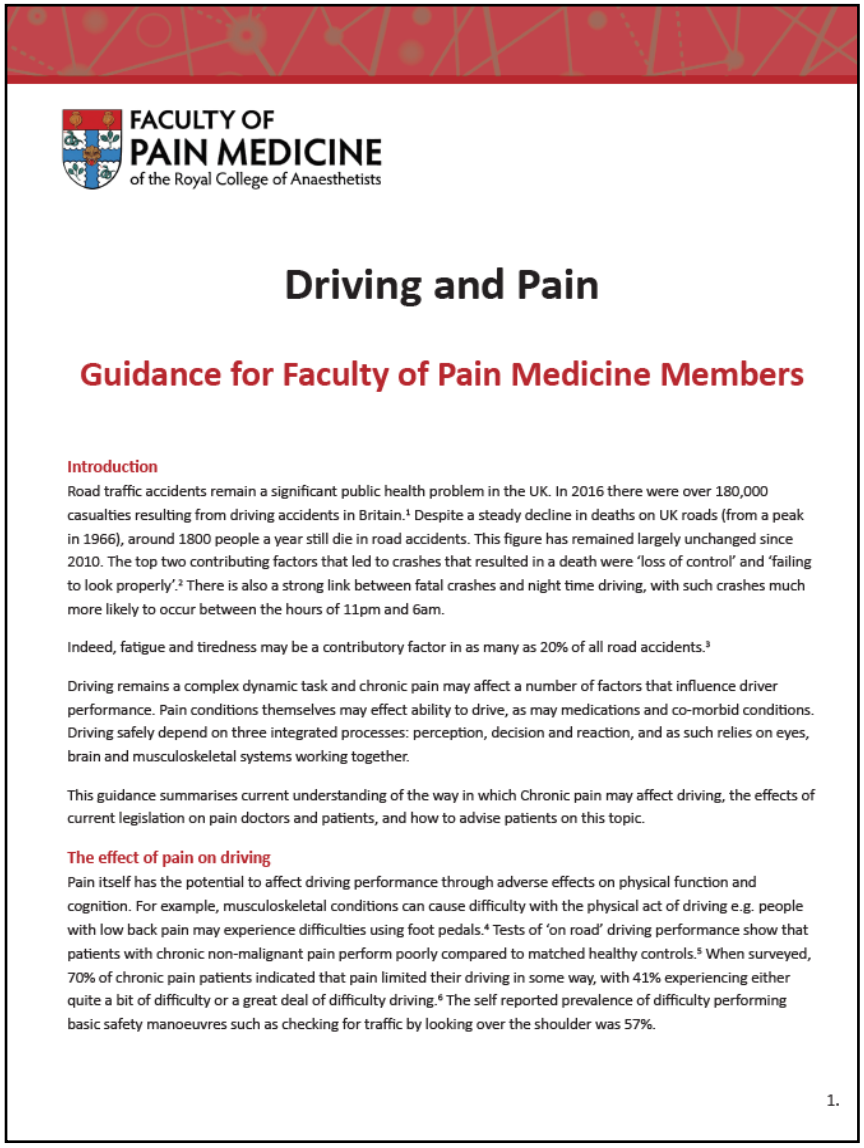
Do not drive if you experience symptoms that may impair your driving such as sleepiness, poor coordination, impaired or slow thinking, dizziness or visual problems. These symptoms can occur as side effects of medication, but be aware that pain itself can also affect sleep, concentration and impair physical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

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

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

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

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



FACULTY OF PAIN MEDICINE
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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.[1] 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'.[2] 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.[3]

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.[4] Tests of 'on road' driving performance show that patients with chronic non-malignant pain perform poorly compared to matched healthy controls.[5] 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.[6] 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 benzodiapines/sedative/hypnotic drugs


The New York Times

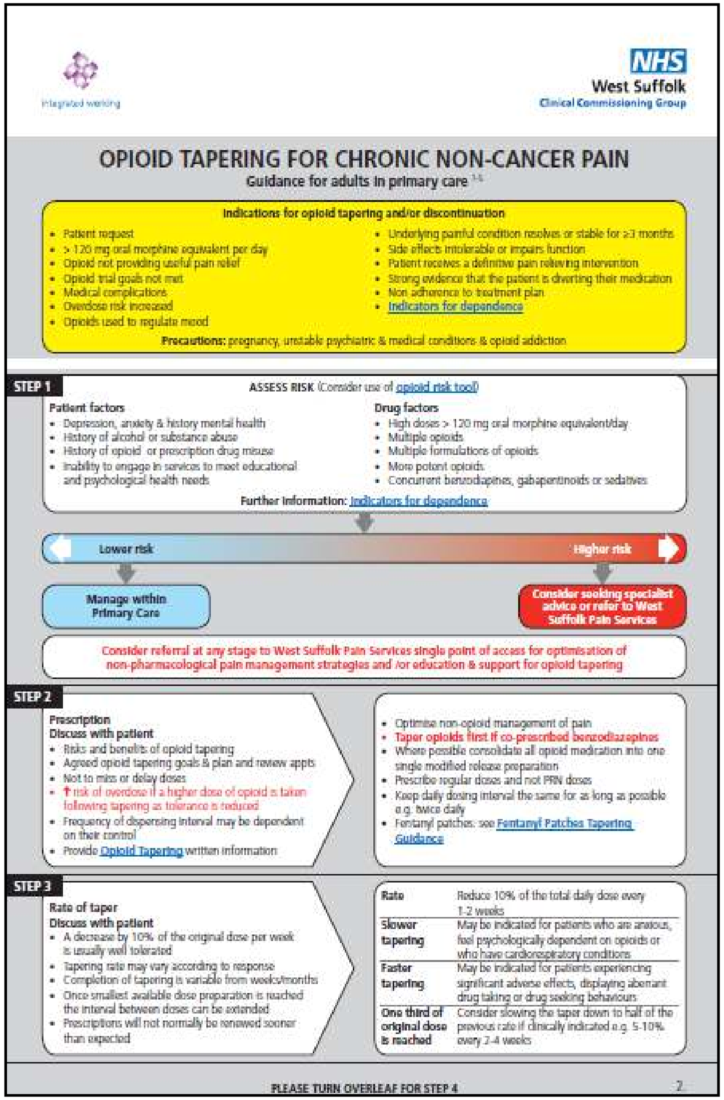
THURSDAY, MAY 24, 2018

KUSHNER APPROVA TOP U

Battling Opioid Overdoses

A fentanyl user and his girlfriend at a supervised injection site in Toronto. New York is interested in opening similar centers. Page A24.

Know the indicators for tapering



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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 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 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

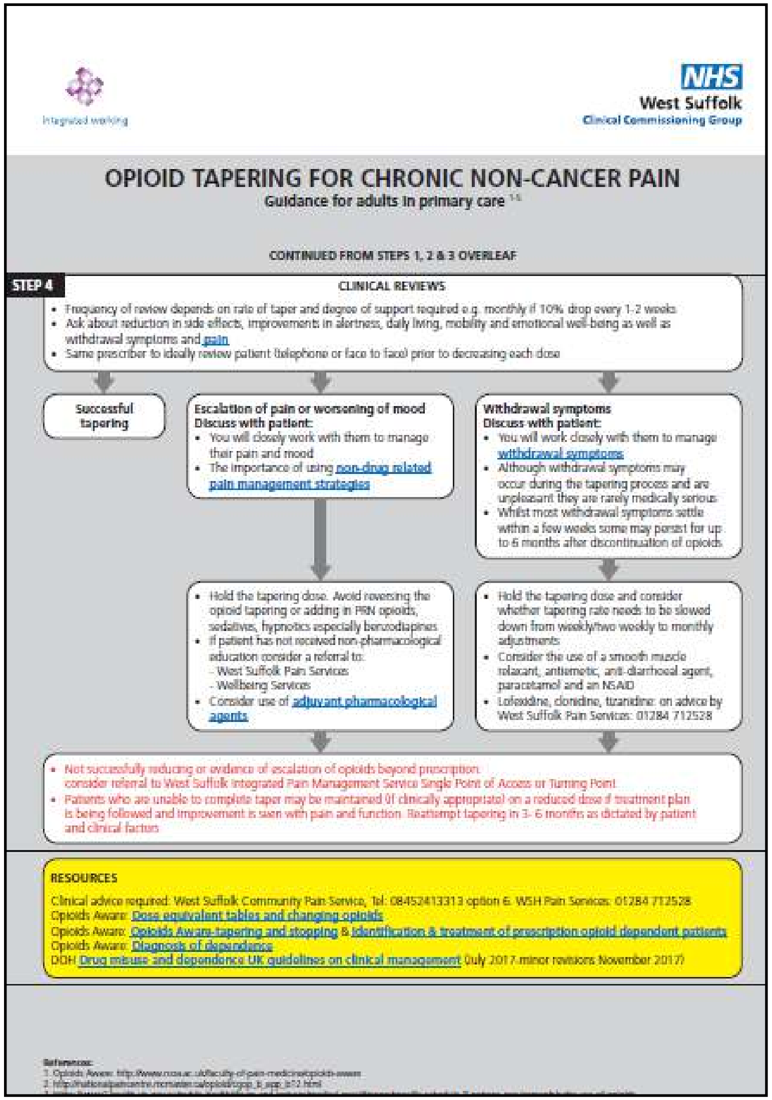
- Optimise non-opioid management of pain
- Taper opioids first if co-prescribed benzodiazepines
- Where possible consolidate all opioid medication into one single modified release preparation
- Prescribe regular doses and not PRN doses
- Keep daily dosing interval the same for as long as possible e.g.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



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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]

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 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, tizanidine: 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 (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 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
DOH 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://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b12.html

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

Recognise drug seeking behaviour

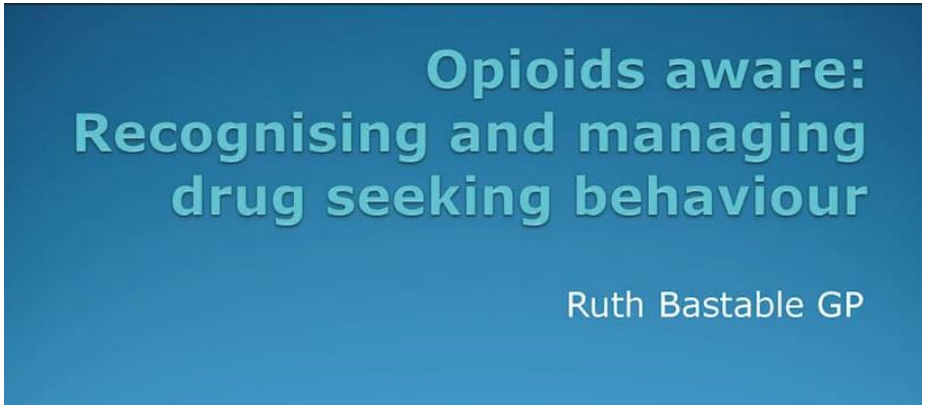
(PresQUIPP 2019)

218. Reducing opioid prescribing in chronic pain 2.2

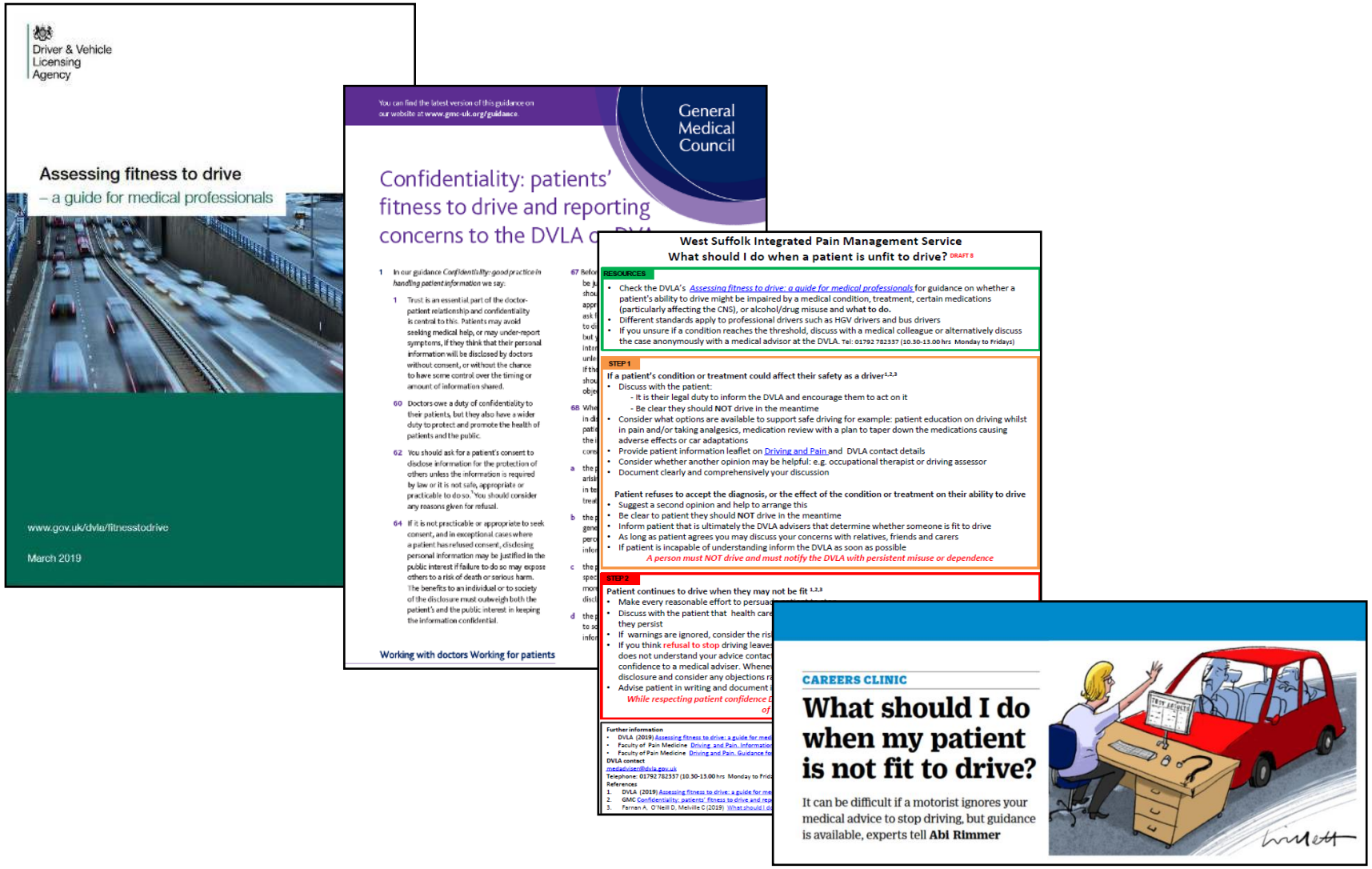
Appendix 2: Indicators that suggest the possibility of dependence that should be explored with those on a long term opioid prescription

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.



Know what do if a patient is unfit to drive?

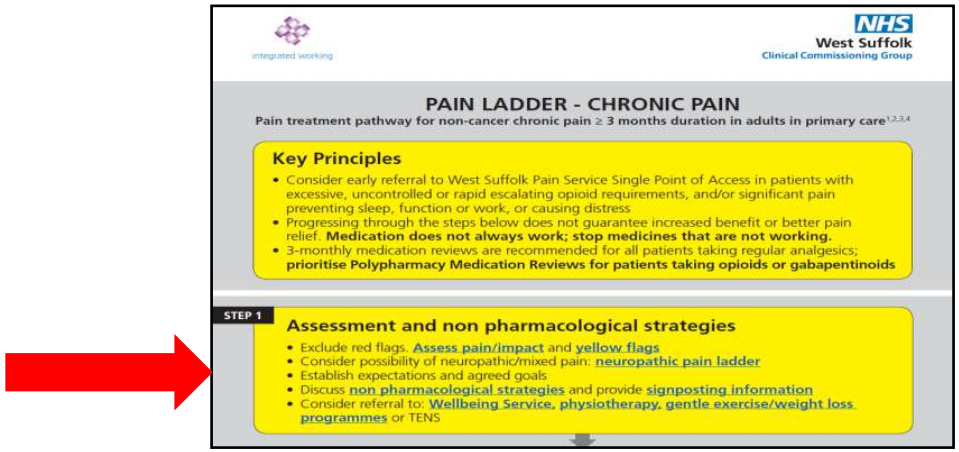


Know how to support self-management

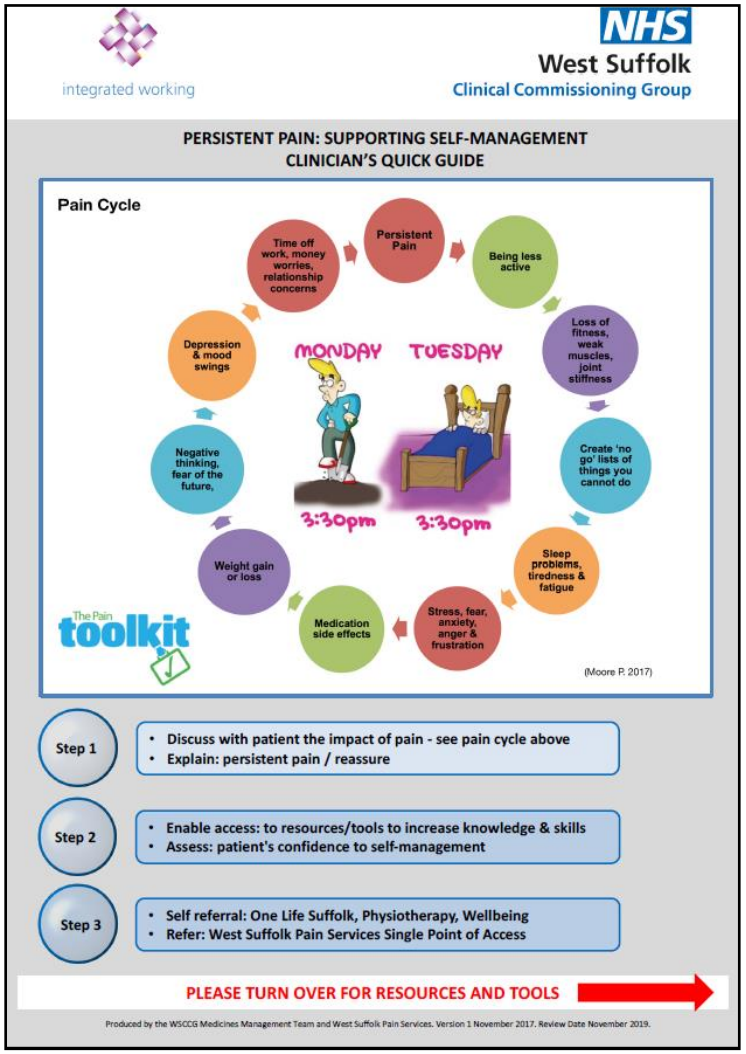
Supporting self-management

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**



Non-pharmacological hyperlinks



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

Pain Cycle

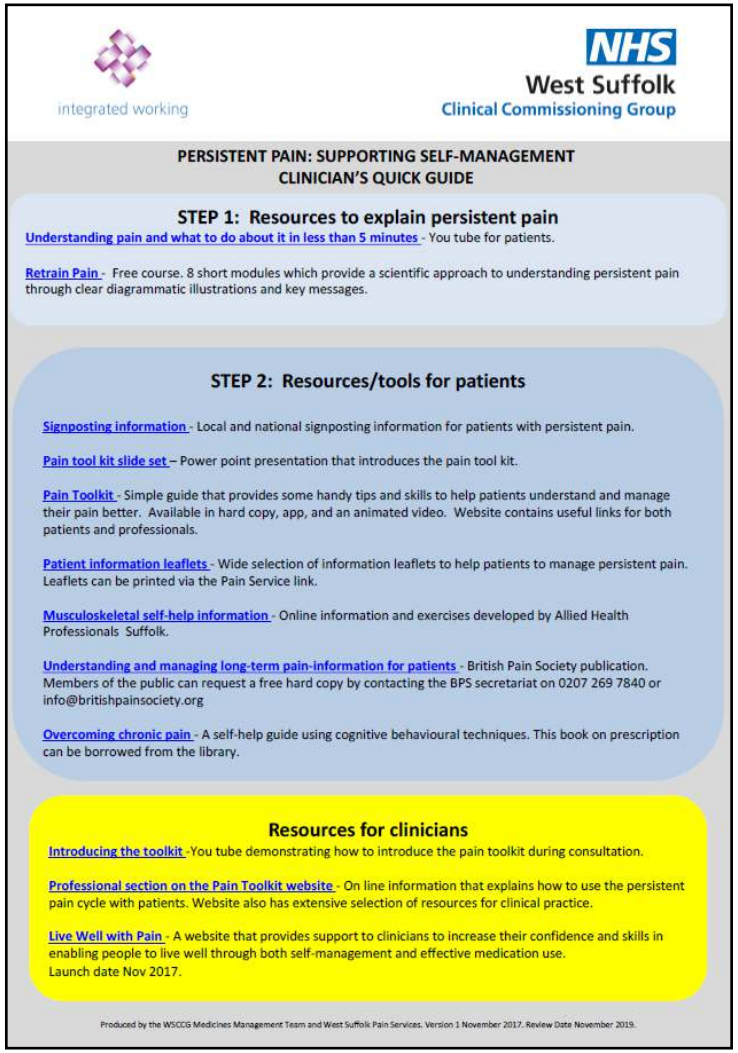
Step 1
- Discuss with patient the impact of pain - see pain cycle above
- Explain: persistent pain / reassure

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.

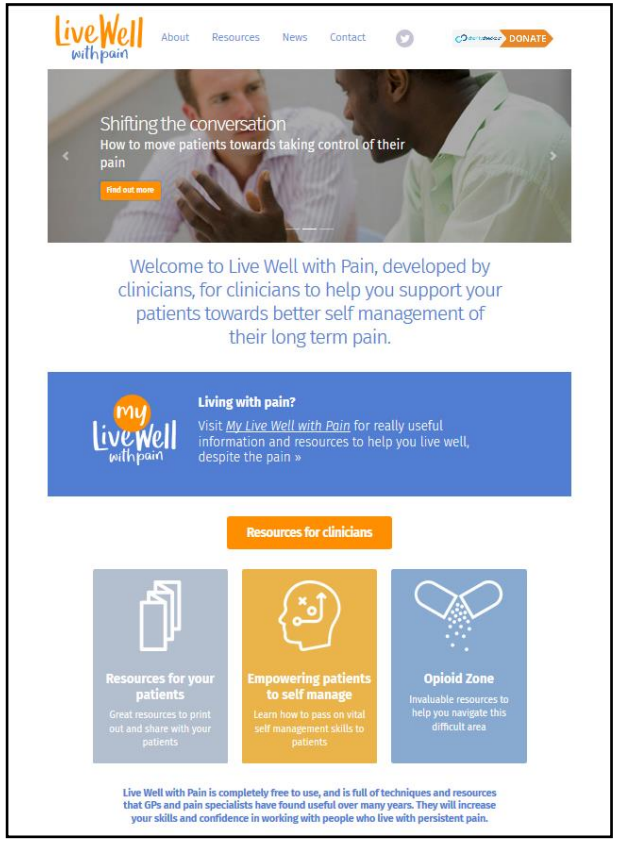
Professional section on the Pain Toolkit website - On line information that explains how to use the persistent pain cycle with patients. Website also has extensive selection of resources for clinical practice.

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.

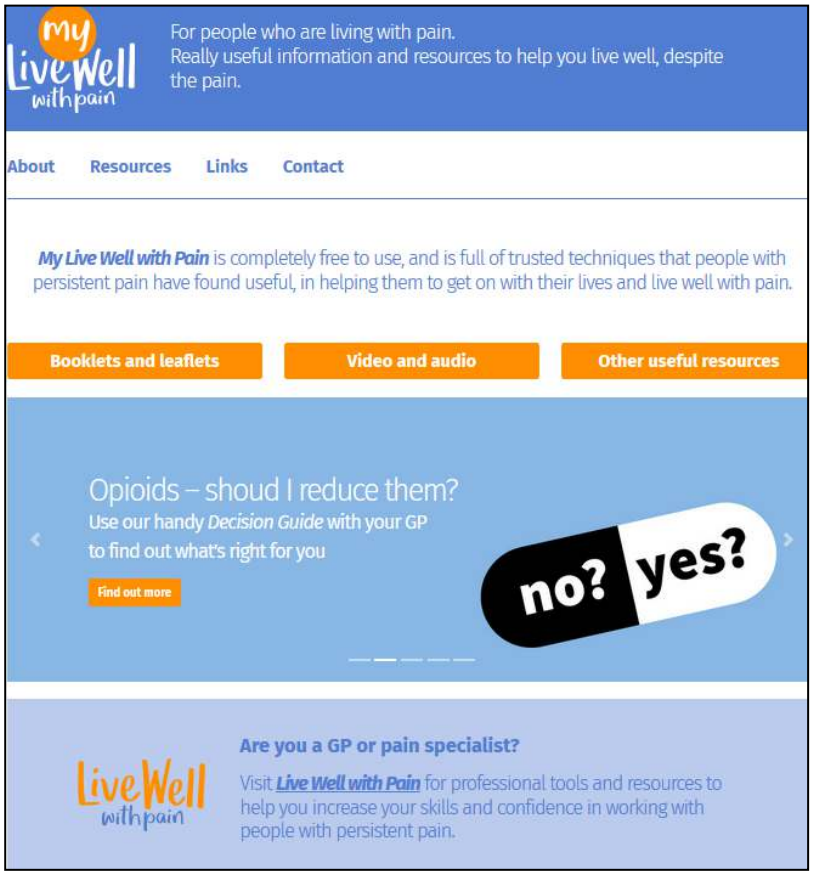
New websites developed by clinicians for clinicians and patients

For clinicians



livewellwithpain.co.uk/

For patients



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

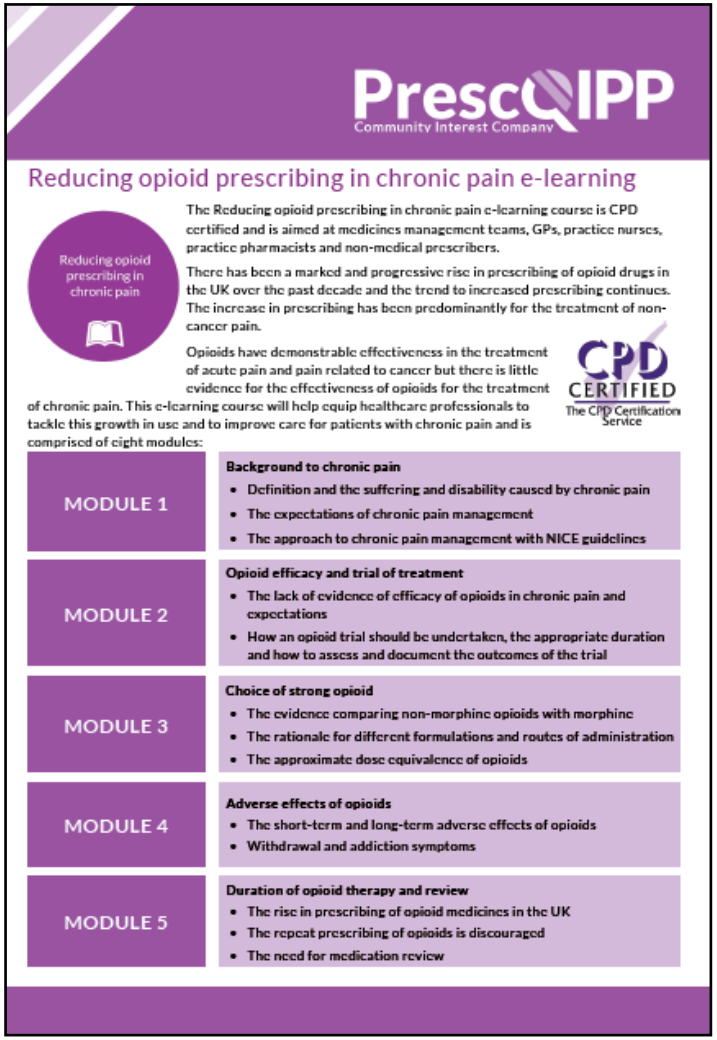
Ten Footsteps to Living Well with

Your Journey with Pain

Sleep problems leaflet

CPD:PrescQuipp

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



PrescQIPP
Community Interest Company

Reducing opioid prescribing in chronic pain e-learning

Reducing opioid prescribing in chronic pain

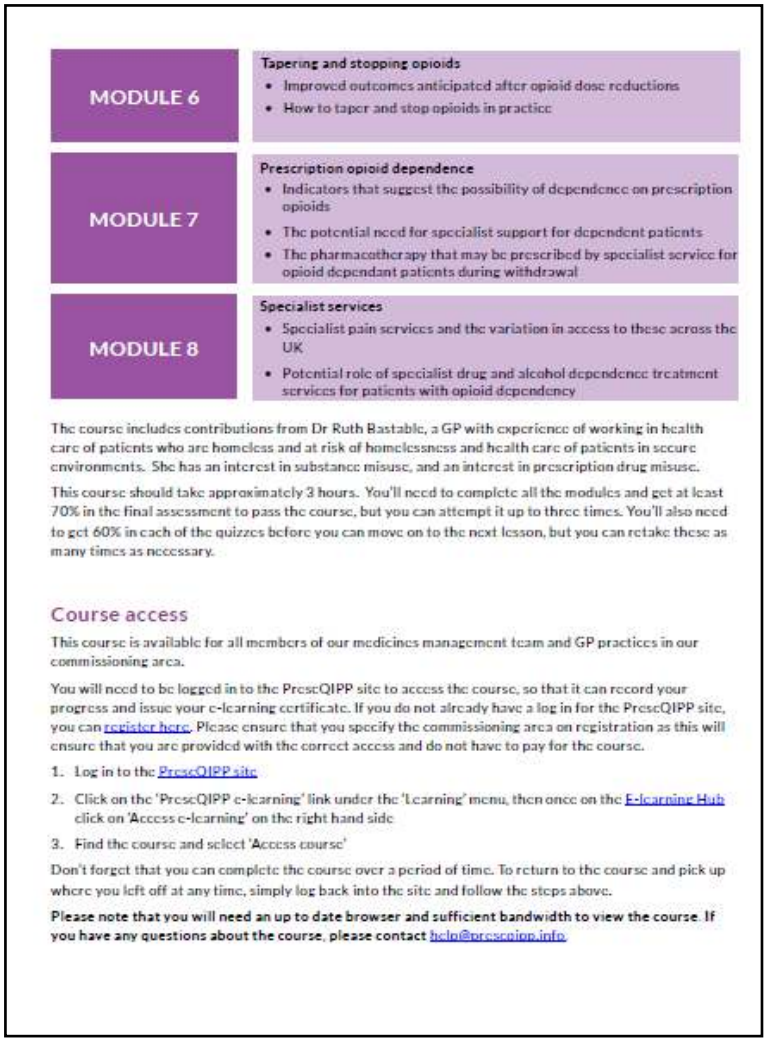
The Reducing opioid prescribing in chronic pain e-learning course is CPD certified and is aimed at medicines management teams, GPs, practice nurses, practice pharmacists and non-medical prescribers.

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:

CPD CERTIFIED
The CPD Certification Service

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 dependant 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.

1. Log in to the PrescQIPP site
2. 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
3. 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

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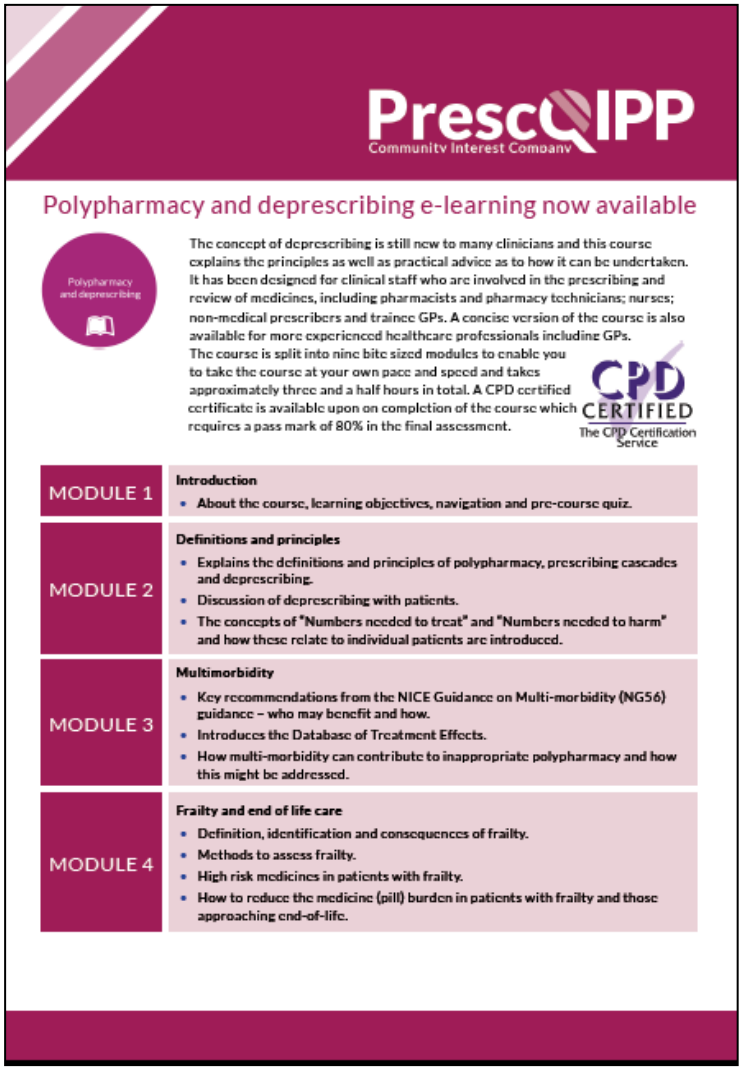

PrescQIPP
Community Interest Company

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 on completion of the course which requires a pass mark of 80% in the final assessment.

CPD CERTIFIED
The CPD Certification Service

MODULE 1	**Introduction** • About the course, learning objectives, navigation and pre-course quiz.
MODULE 2	**Definitions and principles** • Explains the definitions and principles of polypharmacy, prescribing cascades and deprescribing. • Discussion of deprescribing with patients. • The concepts of "Numbers needed to treat" and "Numbers needed to harm" and how these relate to individual patients are introduced.
MODULE 3	**Multimorbidity** • Key recommendations from the NICE Guidance on Multi-morbidity (NG56) guidance – who may benefit and how. • Introduces the Database of Treatment Effects. • How multi-morbidity can contribute to inappropriate polypharmacy and how this might be addressed.
MODULE 4	**Frailty and end of life care** • Definition, identification and consequences of frailty. • Methods to assess frailty. • High risk medicines in patients with frailty. • How to reduce the medicine (pill) burden in patients with frailty and those approaching end-of-life.
MODULE 5	**Medicines optimisation and patient centred care** • Covers key messages from the NICE Guidance on Medicines Optimisation (CG5). • How to take a patient-centred approach to the initiation of new medicines and the review of existing medicines.
MODULE 6	**Shared decision making** • 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. • Introduction to Patient Decision Aids and how to use them.
MODULE 7	**Tools to support medication review** • Importance of medication review. • What is a "gold standard" medication review? • Signposts to (and explains) practical resources for undertaking medication review and deprescribing. • These include tools such as IMPACT, STOPP/START, NO TEARS, 7 Steps, Beers Criteria.
MODULE 8	**Case studies** • Elizabeth: Negative prescribing cascades. • Kathleen: Multimorbidity. • Irene: Reducing pill burden as frailty increases. • Harry: Shared decision making.
MODULE 9	**Final assessment and feedback** • Final assessment: Can be taken up to three times and requires a pass mark of 80%. • Feedback on the course.

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.

1. Log in to the PrescQIPP site
2. 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
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CPD:e-PAIN

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

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 Management Service
Non-pharmacological Services

Education Options

- Understanding pain
- Managing pain
- Pain medication education
- **Opioid education**
- Getting fit to stay or get back to work
- Diet, nutrition & pain
- Sleep & relaxation
- Journey towards change (based on CBT)
- Valued living (based on ACT)
- Education for discharge /admission avoidance

Therapies

- Psychological
- Specialist pain physiotherapy
- TENS
- Hypnotherapy and relaxation
- Mental health pain clinic

Services underpinned by shared decision making., Education and therapies delivered either 1:1 or in groups. On-line learning is available

Suffolk GP FEDERATION

NHS West Suffolk NHS Foundation Trust

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

Suffolk GP FEDERATION

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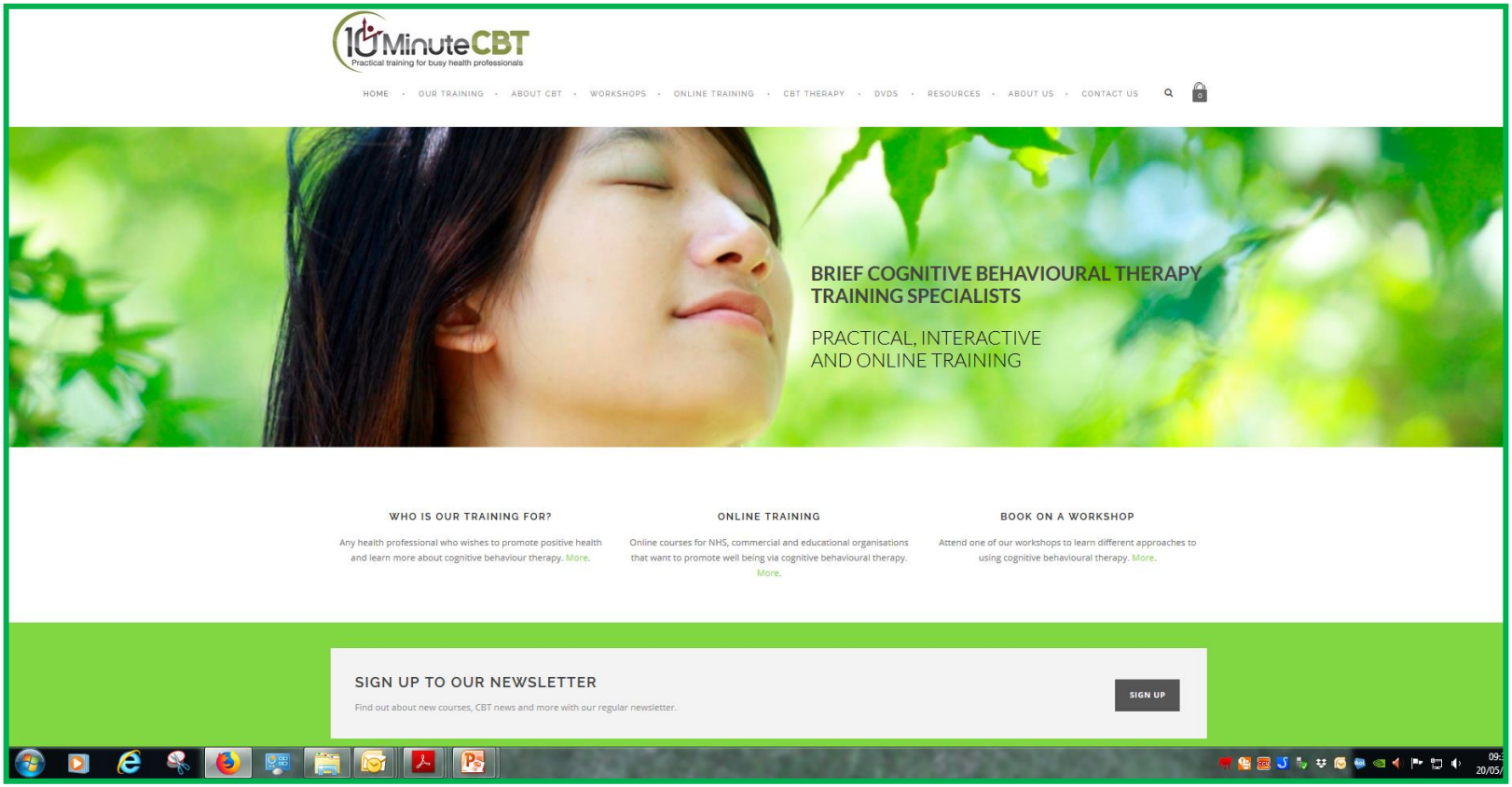
CPD

https://www.10minutecbt.co.uk



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 p
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 misus
medicines and the number of prescriptions of opioid analgesics. The backdrop are the seri
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.

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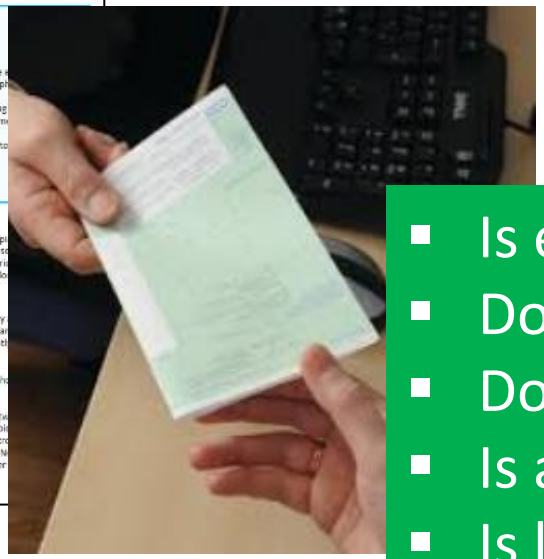

- Is effective for the condition
- Does not harm the patient
- Does not harm anyone else
- Is acceptable to the patient
- Is legal and accurate

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/jdownloads/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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